Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Registrar Amend 28a-b, perME, g872, 10/23/07 TT Certificate of Death 32001 Reg. No.2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month 1:12 P M Logan terald 10 2007 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death  $\mathcal{N}/A$ University of Manyland Medical Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Hours 1**X**M 2□F 512-20-3024 July 6, 1930 Colorada Usual Residence of Decedent 10a State 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 💆 No Jarrettsville Maryland Harford Countil 10e. Street and Number 10g. Citizen of What Country? 2304 Reliance Court united States 21086 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No Specify. Specify: while 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Western Electric 7 Engineer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Forrest Marie M. Logan Losan 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2304 Reliance Court, Tarrottsville, MD 21084 Constance Logar (wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 3/07 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Firmal chapel Forest Hill, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility - Cremting Services - Bel Ar 21. Signature of Funeral Service Licensee - GNA D 3 Nevport Drive Foreht 14:11, MID 21051 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Thum. Approximate Interval Between Onset and Death W. PPROVED BY WEACH. EXIMINES Immediate Cause (Final disease or condition resulting in death) Hernato ma ubdival 430 days Due to (or as a consequence of): Falls Muthole cequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4□Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an autopsy performe rmed? 2. No 25. Was case referred to medical examiner? 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No 28a. Date of Injury 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natoral 8/10/2007 1 ☐ Yes 2 ☑ No Multiple falls 2 Accident

**Physician** /Medical Examiner Examiner be execufed

Department of Health a Important: If Item 27 Is any Injury or other trac

**Physician** 

/Medical

Examiner

**Funeral** 

Director

28a-f show

"natural", or items 23a or 28a-f shov

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I Hygiene.

s 1 and 2 should be filed w f Health and Mental Hygier Item 27 Is marked other th

Pages 1

Baltimore, Maryland 21215-0036

Director

Funeral

Completed

page 2 s

sician and burial-trans attending physician for use as the buria certificate has funeral director this After n 24 hours after death.

ne Funeral Director: A
pletely filled in by the fi death.

Division or Vital Records, P.O. Box 68760,

Physician/Medical Completed by Be Certification: To

within 2 To the

Hospital or Attending

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

3 Suicide

29a. Certifier (Check only one)

4 Homicide

5

29c. License number AI4176435617520

Street Baltimore, MD

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

Reliance Ct., Jarrettsville, MD

28f. Location (Street and Number or Rural Route Number, City or Town, State)

10/1/2007

2304

30, Name and address of pyrson who completed cause of death (Item 23a) (Type, Print)

6 ☐ Could not be determined

Green 32. Registrar's Signature

Registrar

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Place of injury - At home, farm, street, factory, office building, etc. (Specify)

		1- State of Maryland / De State of Maryland /	epartment of He Certificate of De			ene 200	7 32002
Physic /Med		1. Decedent's Name (First, Middle, Last)  Barbara Lois Lilly			2. Date of Death Month 10/3/0		3. Time of Death 3:30 p M
Exami		4a. Facility Name (If not institution, give street and number) Stella Maris	4b. City, Town, or Lo	1		4c. County of De Baltimo	re
Funeral Director		5. Social Security Number 6. Sex 1 M 2 K F 70 Yr  Usual Residence of Decedent 7. Age (In yrs. last births	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day 6/20/19	9. E	Birthplace (State or Foreign Country)  NC
ite, IVIAI yial IN ZIZIOUOOO  Is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene.  Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	Funeral Director	10a. State		oanic Origin? (Spec Mexican, Puerto Fl	ify Yes or No-	Og. Citizen of What USA  14. Race - Ar Black, W	merican Indian,
led within 72 hours after lygiene. her than "natural", or let, the Medical Examination.	Completed by	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)  10 We i	X eccedent's Usual Occupation Give kind of work done during ife. DO NOT use retired) gher&Wrapper	ring most of working	pt	Superfres	
lyidilo	To Be	17. Father's Name ( <i>First, Middle, Last</i> )  Thomas West  19a. Informant's Name/Relationship ( <i>Type, Print</i> )  19b. Name/Relationship (Type, Print)	Aailing Address (Street and	8. Mother's Name Bessie	Hoover		75 Code
Stand 2 sl Stand 2 sl Mealth an item 27 is r		Michael Lilly-Son 42  20a. Method of Disposition 20b. Place of E	03 Ko1b Ave Disposition (Name of crematory or other place)	Baltim	ore, MD		
Dalling C, IV permit. Peges 1 and Department of Health Important: If Item 27 any injury or other tr once.		1 Laborial 2 Dolemation 3 Dhemoval nom state	Hill Cemeter 22. Name and Address	y 10/6/		Brooklyn,	MD  2124  Palt M4.
Cate be executed by Sicilar and Physician and Cate build-transi the burial-transi		23a. Part1. Enter the disease or consist shock, or heart failure. List of one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  CONGESTIVE HEAR!  Due to (or as a consequence of Due	F FAILURE	such as cardiac or	respiratory arre	est,	Approximate Interval Between Onset and Death
the death certific y the attending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ▼ No 9 □ Unknown  23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown	3 □Ectopic pregnancy 5 □ Other (specify)			23d. Date of o Month	delivery Day Year
Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and all director, page 2 should be detached for use as the burial-transi	Completed by Pt	Part II. Other significant conditions contributing to death but not resulting in the	ne underlying cause given	in Part I.	1 ☐ Ye	s 2 No 3 1 24b. Were prior death	
ing Physician: After this certifical	Certification: To Be C	25. Was case referred to medical examiner?  1	atient 3 DOA Other: ne of 28c. Injury a Work? M 1 Ye	at 2 No	(Check only one le 5 ☐ Reside 8d. Describe ho	nce 6 NOther (S w injury occurred reet and Number or	pecify) HOSPCIE  Rural Route Number,
To the Hospital or Attend within 24 hours after death.  To the Funeral Director: k completely filled in by the fu	edical	29a. Certifier (Check only one)  1X Certifying Physician: To the best of my knowledge, 2 Medical Examiner: On the basis of examination and/and manner stated.					
To t Withi	N	29b. Signature and title of certifier	29c. License n	3721	29	10/3/0	onth, Day, Year)
<b>5</b>	ate	30. Name and address of person who completed cause of death (Item 23a) (T.  DR. TARIQ MAHMOOD 2300 DULANEY VAI  31. Date filed (Month, Day, Year)  22. Registrar's Signature		MONIUM, M	D 21093		
Regis		OCT 0 5 2007 Keen &	sele				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 5:30a 2007 10 4 Montgomery Marian /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Md. Baltimore Joseph Richey Hospice If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Days Hours Min. 1 M 2 XF 41 220-84-9517 Director 6-11-1966 Md. Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r 28a-f show notified at 1 Yes 2 □ No Director Baltimore Md. NA 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number with ral", or items 23a or Examiner must be r 5024 Frankford 21206 USA Ave. Funeral 14. Bace - American Indian Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Black 1 ☐ Yes 2 🕱 No Specify: Completed by 3 Widowed 4 Divorced natural 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry event, the Medical 2121 College (1-4or 5+) Elementary/Secondary (0-12) GED NΑ Disabled 18. Mother's Name (First, Middle, Maiden Surname) Baltimore, Maryland 17. Father's Name (First, Middle, Last) Be ould be fi Mental H Brown Albert marked Margaret Dixon 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 Health 205 Laurel Dr. Mt. Wolf, PA. Sister Margaret Brown 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Department of H Important: If ite any Injury or ot once, 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10-5-07 Mt. Carmel Cem. Dundalk, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F.H. East 12 souther Mellow 21202 1101 E. North Ave., Baltimore, Md. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final YRS-25 **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last Due to (or as a consequence of): Examine attending physician and for use as the burial-trar Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐ Eotopic pregnancy Month in the past 12 months? Other (specify) 1 ☐ Yes 2 No 9 ☐ Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 Tyes 2 TNo 3 TProbably 4 TUnknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed death? this certificate 2□ No 1☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence Other (Specify) 2 No 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA SICE 2 completely filled in by the funeral 27. Manner of Death 28a Date of Injury 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred after death. Certification: (Month, Day Year) To the Hospital or Attending 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide

30

Division or Vital

Medical

29a. Certifier

29b. Signature and title of certifier

31. Date filed (Month, Day,

State Registrar

within 24 hours a To the Funeral I

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and/manner stated. 29c. License number

29d. Date signed (Month, Day, Year)

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Catherine Marie May October 0 2007 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Mariner Care - Rossville Baltimore Baltimore 5. Social Security Number 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Months Days Hours 218-46-1468 Dec. 13, 1919 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Maryland Harford Belcamp 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4800 Water Park Drive Unit R 21017 U. S. A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No Specify Specify 3 Widowed 4 □ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 10 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Michael Vogel Barbara Gross 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy M. Allegro (daughter) 4800 Water Park Dr., Unit R, Belcamp, Md. 21017 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Moreland Memorial Pk. 10/08/2007 | Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Schimunek Funeral Home Inc. 21. Signature of Funeral Service Licenses 9705 Belair Rd, Nottingham, Maryland 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate

Physician /Medical **Examiner** 

permit. Pages 1 an Department of Healt important: if item 27 any injury or other tr. once.

Physician

/Medical

Examiner

Director

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**Funeral** 

Director

should be filed within 72 hours after death with the Maryland alth and Mental Hygiene.
27 is marked other than "natural" ~ " " traumatic event the marked other than "natural" ~ "..."

1 and 2 should be 1 Health and Mental

Baltimore, Maryland 21215-0036

sician and burial-tran

P.O. Box 68760

Records,

Vita

To the Hospital or Attending Physician: within 24 hours after death,

To the Funeral Director: After this certifica completely filled in by the funeral director. F

ted by Physician/Medical	completed by Physician/Medical	CJ.	To Be Completed by Physician/Medical
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ted by Phys	completed by Phys	CJ.	ro Be C
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	Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as a consequence of):			Onset and Death
Completed by Physician/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d.	Deelme		
ıysician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown		pic pregnancy er (specify)	23d. Date Mont	
ted by Pn	Part II. Other significant conditions of	contributing to death but not resulting in the underly	ing cause given in Part I.	23e. Did tobacco use contrib	oute to the cause of death?
Comple				autopsy pri	ere autopsy findings available or to completion of cause of ath? □Yes 2 □ No
Be	25. Was case referred to medical examiner?	11		h (Check only one)	
9	1 ☐ Yes 2 ☐ No	Hospital: 1 Inpatient 2 ER/Outpatient 3	DOA Other: 4 Nursing Ho	me 5 Residence 6 Other	(Specify)
ation:	27. Manner of Death  1 ☐ Natural 5 ☐ Pending  2 ☐ Accidentinvestigation		28c. Injury at Work?	28d. Describe how injury occurred	d
Certific	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined		actory, office	28f. Location (Street and Number City or Town, State)	or Rural Route Number,
edical Certification:	29a. Certifier (Check only one) 1 ☐ Gertifying Ph	nysician: To the best of my knowledge, death occi miner: On the basis of examination and/or investig and manner stated.	urred at the time, date and place, action, in my opinion, death occur	and due to the cause(s) and man red at the time, date and place, ar	ner as stated. nd due to the cause(s)
Ž	29b. Signature and title of certifier		29c. License number	29d. Date signed	(Month, Day, Year)
	Dave	mD m	D31464	1010	4107

State Registrar

DHMH 17 Rev 1/2001

BALTIMOREMIN

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
SHOAII? A. HASHMI, &ZIN. EYTAW St Funte 30 f.

32 Registrar's Signature

MASHMI

31. Date filed (Month, Day, Year)
OCT 0 5

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 2<u>007</u> Month **Physician** 04, Oct. Betty Virginia Nelson 6:44 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Gilchrist Hospice Center Towson If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 12.19.1929 9. Birthplace (State or Foreign Country) 5. Social Security Number Age (In yrs. last birthday) **Funeral** Hours 1□ M 2 Days 214.26.1861 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State "natural", or items 23a or 28a-f show 1 ☐ Yes 2 No **Funeral Director** MD Baltimore Parkville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21234 U.S.A. 8208 Harris Avenue s 1 and 2 should be filed within 72 hours after death v of Health and Mental Hygiene. Then 27 is marked other than "natural", or thems 23e other traumatic event, the Merleal Examiner must 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black White etc. 1 Yes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 2D No 1 🗆 Yes Specify: White Completed by 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be f nent of Health and Mental I Albert Melson Doris Smith ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ralph Nelson/Husband 8208 Harris Avenue, Parkville, MD 21234 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of IImportant: if Ite any Injury or ot once. 1 ☐ Burial 2 ☐ Fremation 3 ☐ Removal from State Chesapeake Crem. 10.05.07 Beltsville, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Cremation And Funeral Balto 21. Signature of Funeral Service Licenses Alternatives 8717 Green Pastures Dr. MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** YLAVS Due to (or as a confequence of): disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner law requires that the death certificate be executed and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown Month Day Year 4☐ Pregnant at time of death 5 Other (specify) ed by the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 1 ☐ Yes 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an After this certificate has funeral director, page 2 s 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Ather (Specify) Wisp ( 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 Naturai Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Hospital or Attending To the nosperation 24 hours after death.

To the Funeral Director: Af the

(Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated 29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year) OCTUBER 4 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Charles ST TENSUN ND 21204 6701 N-HMRON J. CHARLIES NO

State Registrar

within 24 hours af

To the Funeral C

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State Registra

29b. Signature and title of certifier

31. Date filed (Month, Day,

and address of person who completed cause of death (Item 23a) (Type, Print) 3001

32. Registrar

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2007

DHMH 17 Rev 1/2001

29d. Date signed (Month, Day, Year)

	For State	State of Ma	ryland / Dep	artment of H		Mental Hy	giene Reg. N <b>2</b> 0	07	32007
*	Registrar  1. Decedent's Name (First, Middle,	( ant)		Timeate of I	Jeani	2. Date of De		J 1	3. Time of Death
Physician	1. Decedent's Name (First, Wilddle,	- Day				Month	Day	Year	3. Time or Death
/Medical	MESTER	rery		4b City Tayra a	Logotice of Dec	SEL	40 Count	<del>00+</del>	820 F
Examiner	4a. Facility Name (If not institution,	give street and number)	0 =	4b. City, Town, or	Location of Dea	$^{\rm m}$	4c. County		City
	5. Social Security Number	6. Sex 7. Age	(In yrs. last birthday	If Under 1 Year	If Under 24 Hrs	8. Date of Bir		More	COO (State on Foodier
Funeral		1. XM 2 ☐ F	Vrc	Months Days	Hours Min	. (Month, Da	y, Year)	Count	
Director	217-56-9878 Usual Residence of Decedent		55			NOV 14	1951	NEW	YORK
land land	10a. State 10b. County	Ï	10c. City, Town or L	ocation				10	0d. Inside City Limits
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vith the Mar or 28a-f sl be notified	MARYLAND N/A	1	BALTI	10f. Zip Code			10g. Citizen of	What Coun	trv?
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ING 21213-UU36  be filed within 72 hours after death with the Maryland tital Hygiene. do other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at  Be Completed by Funeral Director	11. Marital Status	12. Was Decedent E	ver in U.S. 13			Snecify Yes or No		ce - America	an Indian.
ter d	1 ŽNever Married 2 Marrie	Armed Forces?	0	Was Decedent of H If Yes, specify Cuba	an, Mexican, Pue	rto Rican, etc.)	Blac	ck, White, e	
OU36 hours after tural", or ite		If Yes, Give Year or Dates:		1 ☐ Yes 2 ☒ No	Specify:		Specif	y: BLA	CK
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within 72 ene. than "nai he Medic	(Specify only highes Elementary/Secondary (0-12)	t grade completed)	(Giv	e kind of work done DO NOT use retired	during most of wo i)	orking			
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nd 2121 be filed within tal Hygiene " d other than " event, the Me Be Comple		Last)			18. Mother's Na	me (First, Middle			
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TOFE, Maryla ggs 1 and 2 should th of Health and Mer if item 27 is marke or other traumatic	19a. Informant's Name/Relationsh		19b. Mai	ling Address (Street	and Number or F	Rural Route Numb	er, City or Town	State, Zip	Code)
and 2 sh and 2 sh ealth and n 27 is n er traun	Mildred Murdock	/Sister	1.5	25 Upshir	e Rd., E	Baltimore	. Marvl	and 2	1218
re, IV 1 and 2 1 Health tem 27 i	20a. Method of Disposition	.,		osition (Name of ematory or other place		Date	20c. Location		
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altimo mit. Pages partment of portant: If i y Injury or oe.	4 □ Donation 5 □ Other (Sp. 21. Style at all e of Funeral Service I		-	MORIAL PA		-08-07	BALTIMO	-	
baltimore permit. Pages: Department of P Important: If ite any Injury or of	21. Service t	logiser /		22. Name and Addre					
	Juvach			1206 W NO				21217	
	23a Fart1. Enter the disease, or shock, or heart failure. List	only one cause on each lin	e.	nter the mode of dyir	ig, such as cardia	ac or respiratory a	rrest,		Approximate Interval Between Onset and Death
Physician	Immediate Cause (Final disease or condition resulting in death)	_a Ch	muco	Kidney	. disea	160			
/Medical Examiner	resulting in death)	Due to (or as a	a consequence of):	0					
Lammer	. Sequentially list conditions,	b							
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		d			<del></del>				
box 68/ death certificate e attending phys d for use as the	IF FEMALE:							- 1	
hat the death certification of by the attending letached for use as Physician/Me	23b. Was decedent pregnant in the past 12 months?		2 Fetal death 3	□Ectopic pregnancy	/			ate of delive onth	ery Day Year
he a he de fe	1 Yes 2 No	4☐Pregnant at 9☐Unknown	time of death 5	Other (specify)			No.	211(11	Day Teal
COLOS, P.O.  w requires that the di been signed by the should be detached	9 □ Unknown					00 8:11	, -		
2 ± 0 >		ns contributing to death bu	it not resulting in the	underlying cause giv	en in Part I.				ne cause of death?
law requires as been sign 2 should be						10	Yes 2No	3 ☐ Prob	ably 4 Unknown
The law requirence to the law requirence to the law requirence to the law requirence to the law requirements the l						24a. Was	an 24b.	Were autor	psy findings available mpletion of cause of
T e e e						perfe	ormed?	death?	2X No
VITAI Ician: T Pertificat ector, pa	25. Was case referred to medical			<del></del>	26. Place of De	eath (Check only			23
Or VITA Physician: rthis certific ral director,	1 Yes 2 No	Hospital: Impatie	nt 2 ER/Outpatio	ent 3 DOA Oth	er: 4 Nursing	Home 5☐Res	idence 6 □Ot	her (Specif	v)
g Phy g Phy ter this neral d		28a. Date of Injur	y 28b. Time				how injury occu		
atio	1 Natural 5 ☐ Pending 2 ☐ Accident investig		rear) Injury		Yes 2 □ No				
DIVISION ( Ital or Attending F s after death al Director: After led in by the funer.  Certification:	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determi	not be 28e. Place of inju	ry - At home, farm, s c. (Specify)	treet, factory, office				ber or Rura	I Route Number,
	4 LI Hornioldo	building, etc	. (Specify)			City of 10	wn, State)		
		g Physician: To the best							
the Hosp ithin 24 hou the Fune ompletely fil	(Check only 2☐ Medical one)	Examiner: On the basis of and manner sta	examination and/or ited.	investigation, in my	opinion, death oc	curred at the time	, date and place	, and due to	the cause(s)
To the Vithin To the Somp	29b. Signature and title of certifier			29c. Licens			29d. Date signe	ed (Month,	Day, Year)
	1 Mar	2m)_	-MD	AU41-	76435	T18209	OCT	1	2007
	30. Name and address of person	who completed cause of de	eath (Item 23a) (Tyne						WU T
W	301 St Day	1 St. Ba	timere	mo:	21202	_			
State	31. Date filed (Month, Day, Year)	32. Registra	ar's Signature	M. D					
Registrar	0	007 Alexan	15 1400						

			For State Registrar	State of Ma	ryland / Depa	artment of rtificate of		d Mental Hy	giene	007	320	800
	Physici	an	1. Decedent's Name (First, Middle, Las	•				2. Date of De Month	eath Day	Year	3. Time of	Death
	/Medic	cal	BERNARDINE M. PAR  4a. Facility Name (If not institution, give			4b. City. Town.	or Location of D	OCT	4c. Co	2007 unty of Death	3:30	a <sup>M</sup>
1 Sec. 1	Exami	le i	101 CREEK VIEW CT			STREET				RFORD		
	Funeral Director		217-03-1760	□M 2□XF	(In yrs. last birthday) 9 Yrs.	If Under 1 Yea Months Days		Hrs. 8. Date of Bi	a <i>y</i> , Year)	9. Birthp Cour	place (State on try) PA	r Foreign
	and w		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or Lo	ocation				1	0d. Inside Ci	ty Limits
	be filed within 72 hours after death with the Maryland tial Hygiene. Id other than "natural", or items 23a or 28e-f ehow event, the Medical Examiner must be notified at	Funeral Director	MD HARFOR	D	STREET						1 🗋 Yes	-
	with the	Dire	10e. Street and Number			10f. Zip Code			_	of What Cour	ntry?	
	ms 23	nera	101 CREEK VIEW CT	12. Was Decedent E		21154 Was Decedent of	Hispanic Origin	? (Specify Yes or No	USA 0- 14.	Race - Americ	an Indian,	
98	or ite	/ Fur	1 Never Married 2 Married	Armed Forces?  1 Yes 2 XN  If Yes, Give	o			uerto Rican, etc.)		Black, White, ecify: TTTT		
Ö	hours turaf',	ed by	3 Widowed 4 Divorced  15. Decedent's Ed	Year or Dates:		1 ☐ Yes 2 ☐ No				WH.	ITE .	
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Maryland	should be fill and Mental H marked oth	To Be	17. Father's Name (First, Middle, Last) HENRY LOUIS MANKE					Name (First, Middle LOUISE SO)		mame)		
Mary	s 1 and 2 should f Health and Mer item 27 is marks other traumatic		19a. Informant's Name/Relationship (7			ng Address (Stree		Street, I			Code)	
Baltimore,			20a. Method of Disposition  1 □ Burial 2 □ Cremation 3 □		20b. Place of Dispo		1	Date		ion - City or To	own, State	
Ħ	rtmer rtmer rtant njury		4 Donation Other (Specify 21. Signature of Funeral Service Lie	)	Metro Ci	rematory 2. Name and Add		0/4/07	Balti	more, N	<u>D</u>	
Ba	Depa impo any i		21. Signature of Full district Service Electric		7	Mille -	Dennel	7.H. 104	IT BO	Salto	of Ind.	1206
			23a. Part1. Enter the disease, or come shock, or heart failure. List only	plications that caused to he cause on each line	the death. Do not ent	ter the mode of dy	ing, such as car	rdiac or respiratory a			Approximate Interval Bet	e ween
F. ye	Physician /Medical		tmmediate Cause (Final disease or condition resulting in death)	· Myo	cardia	el Iv	1 Farc	STION			Onset and E	Jeath
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9	n certifica inding phi use as th	8	IF FEMALE:									
Вох	eath certif attending for use as	lan/I	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1 Live birth 2 4 Pregnant at t	Fetal death 3	Ectopic pregnan	су		23d	Date of delive		Year
P.O.	t the de	Physician/M	1 ☐ Yes 2 Mo 9 ☐ Unknown	9☐ Unknown	me or death 5L	Other (specify)						
	The law requires that the death certificate sie hes been signed by the attending pthys bage 2 should be detached for use as the	þ	Part II. Other significant conditions of	-		a 1 1				contribute to the		r
Records,	w requi	eted	1137019 104	Polmen	cery z	mbol	05	-	Yes 2□N			Jnknown
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/ita	cian: ertifica ector.	Bec	25. Was case referred to medical examiner?					Death  Check only				
of o	Physi r this c ral dire	2	1 ☐ Yes 2 No 27. Manner of Death	Hospital: 1 ☐ Inpatien 28a. Date of Injury		" 30 DOA		ng Home 5 Res			y)	
ion	Attending Physician: r death. sctor: After this certifice by the funeral director.	ation	1 Natural 5 Pending 2 Accident investigation	(Month, Day	Year) Injury	W	ork? □Yes 2 □No	28d. Describe	now injury or	zanea		
Division of Vital	il or Atte after des Directo Jin by th	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Ptace of Injur building, etc.	y - At home, farm, str (Specify)	reet, lactory, office	9	28l. Location City or To	(Street and Nown, State)	umber of Rura	al Route Num	ber,
	To the Hospital or Attending Physician: The I within 24 hours after death.  To the Funeral Director: After this certificate he completely filled in by the funeral director, page	edical C	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best of tiner: On the basis of and manner state	examination and/or in	h occurred at the vestigation, in my	time, date and p	place, and due to the occurred at the time	cause(s) and date and pla	d manner as s	tated. the cause(s	)
	To the within 2 To the complet	Me	29b. Signature and title of contifier				nse number		29d. Date s	igned (Month,	Day, Year)	
÷	,		MOU	115		D5	514	3	10	14/6	ッチ	
	5		30. Name and address of person who	completed cause of de	ath (Item 23a) (Type,	Print)	Le RI	Bel Ai	- m	8 7	1015	
	Sta		31. Date liled (Month, Day, Year)	32. Registrar	's Signature		0 100	Del Al	, , , , ,	~ ~	, )	
	Registr	ar	OCT 0 5 2007	Della	It from	E .						

State of Maryland / Department of Health and Mental Hygiene 32009 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** October Robinson 1250 Delores 200 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner HOPKINS Johns Hospital Raltimore Cit The If Under 1 Year | If Under 24 Hrs./ 9 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months Days Hours 1□M 2⊠F 9 an Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location or 28a-f show other traumatic event, the Madical Examiner must be notified at 1 **V**es 2 □ No Completed by Funeral Director 10g. Citizen of What Country? 10e. Street and Number 52 or Items 23a 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 DNo Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No If Yes, Give Year or Dates: Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced a "naturel", Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Peges 1 and 2 should be filed within Depertment of Health and Mental Hygiene. Important: if item 27 is marked other then eny injury or other traum-11. Elementary/Secondary (0-12) College (1-4or 5+) er 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame, Be ( ပ 1am 19a. Informant's Name/Relationship Type, Print) Husband 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Sta 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 12007 Cemetery \* 4 ☐ Donation 5 ☐ Other (Specify) 23a. P.Int. Enter the dilease, or complication is that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, disease or condition resulting in death)

22. Name and Address of Facility

23. P.Int. Enter the dilease, or complication is that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, and disease or condition resulting in death) 22. Name and Address of Facility once. Approximate Interval Between Onset and Death set and Death Week **Physician** /Medical **Examiner** ntestinal lung Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner cleroderma the attending physicien and hed for use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, IE FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal dea
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy detached for in the past 12 months? Year Month Day 5 Other (specify) 9☐ Unknown 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 2 No 3 Probably 4 Unknown 1 ☐ Yes Be Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No this certificate has 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) axaminer' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Impatient Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Yeer) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? or Attending Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident hours after death uneral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funeral D the Hospitel 29a. Certifier Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Unack only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29h Signature and title of certifier 29c. License number , MA 2007 RES - 000 32. Registrar's Conatural STREET, BACTIMORE MS 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RITH-ELTE ABBULNOU 31. Date filed (Month, Day, Year) State 0 5 2007 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** George Jacob Ruhl, Jr. 2007 6:10P October 0 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gilchrist Center Baltimore Towson If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months 1 X M 2 □ F Yrs. Director March 4, 1930 216-28-1722 77 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2X No Director Perry Hall Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U. S. A. Funeral 9600 G. Haven Farm Road 21128 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black White etc. 1 X Yes 2 No 1948 - If Yes, Give 1949 Year or Dates: 1949 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Completed by Specify: White 3 Widowed 4 Divorced 1949 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Technician Telephone Company 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be George J. Ruhl, Sr. Teresa Hoffman ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Important: if item 27 any injury or other tr once. 9600 G. Haven Farm Road, Perry Hall, Maryland 21128 Elizabeth Ruhl (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Greenmount Cemetery 10/05/2007 | Baltimore, Maryland 22. Name and Address of Facility Schimunek Funeral Home Inc. 21. Signature of Funeral Service Licensee 9705 Belair Road, Nottingham, Maryland 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) ena aranoma /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of): The law requires that the death certificate be executed the burial-trar Due to (or as a consequence of): Box 68760, as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day 4□Pregnant at time of death P.O. I 5 Other (specify) ned by the a detached f 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by LIVI melastases 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Vinknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No page 2 s autonsv perform To the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) VOS PLG 1 ☐ Yes 2 ☐ No Certification: To within 24 hours after death.

To the Funeral Director: After th
completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide VErtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29c. License number 29d. Date signed (Month, Day, Year)

5 State

DHMH 17 Rev 1/2001

Registrar

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Housem

32-Registrar's Signature

6701

Charles St Toward MA 21204

07-07687 Sedrick Reid with 0

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2007 3201 1- For State Certificate of Death Reg. No Registra 1. Decedent's Name (First, Middle, Last) Physician/ 2. Date of Death 3. Time of Death **Medical Examiner** Month Day October 1, 2007 Sedrick 1636 hrs Reid 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Bon Secours Hospital Baltimore NA **Funeral** 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24Hrs 8. Date of Birth (MM/DD/YYYY 9. Birthplace (State or Days oreign Director Months Hours Min 220-86-4616  $_{1}X_{M}$ Country) Md. 3-4-1968 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits NA Baltimore Md. 1 X Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country 1920 E. 31st Street 21218 USA Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 X Never Married 2 White, etc. Married 2 X No Yes Widowed If Yes, Give Year 4 Divorced Yes 2 X No specify Specify: þ Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) be filed within 72 College (1-4 or 5+) 8th grade Cotten Construction Cd. NA Construction Worker Mental Hygiene. 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Charles Reid henry Be Ε. Mary Moore Pages I and 2 should nent of Health and Me 19a. Informant's Name/Relationship (Type, Print ) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Moore 1920 E. 31st Street, Baltimore, Md. Mother 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State crematory or other place 1 Burial 2 Cremation 3 Removal from State 10-8-07 Randallstown, Md. King Mem. Pk. Other Specify: Donation 5 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F.H. East 1101 E. North Ave., Baltimore, Md. 21202 Wan 23a. Part I. Enter the disease, 🔊 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Approximate Interval failure. List only one cause on each line Between Onset and /Medical Narcotic (methadone and Heroin) intoxication and cocaine use Immediate Cause (Final disease raminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Examiner Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit Physician/Medical ysician a burial -X UNPENDED Box 68760, he death certificate be e perME, g872, 10/11/07 TI tending physuse as the b IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Live birth Ectopic pregnancy 3 Fetal death Month Day Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown g Unknown of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Yes 2 No 3 Probably 4 ✔ Unknown Completed page 2 should 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? Yes 2 1 🗸 Yes the Hospital or Attending Physician; 25. Was case referred to medical 26.Place of Death (Check only one) æ examiner? Hospital: this Inpatient 2 V ER/Outpatient 3 Nursing Home 5 Residence 6 2 1 ✔ Yes 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division Natural Pending Yes 2 X No the FNd 10/1/2007 Fnd 4:14 pm Accident Investigation filled in by 24 hours after de Funeral Direc 28f. Location (Street and Number of Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 6 X Could not be Suicide 1720 W. Lafayette Ave. determined Homicide house completely Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 2 Wedical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifie 29c. License numbe 29d. Date signed (Month, Day, Year) O.C.M.E October 2, 2007

DHMH 17 Rev 1/2001 **OCME 2006** 

State Registra

**ORIGINAL** 

30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner

Registrar's Signature

Pamela E. Southall, MD

OCT O

31. Date filed (Month, Day, Year)

111 Penn Street, Baltimore, MD 21201

				epartment of Health and N Certificate of Death		2007	32012
1		٠,	Decedent's Name (First, Middle, Last)		2. Date of Death	. 110,	3. Time of Death
п	Physici		Christopher Ropach		Month Oct.	Day 4 2007	5:00 a <sup>M</sup>
	/Medic Examir		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	3.00 u
	Exami	iei	4230 Crystal Ct. Apt. 3C	Hampstead		Carrol	1.
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birtho	fay) If Under 1 Year   If Under 24 Hrs.	8. Date of Birth	9. Birthol	lace (State or Foreign
ы	Director		214-88-7593 XXM 2□F 30 Yrs	s. Months Days Hours Min.	Jan. 6	ea <i>r) Coun</i> i	try) th Dakota
	D		Usual Residence of Decedent		Touris o	71571 500	cii bakoca
	rylan how		10a. State 10b. County 10c. City, Town o	r Location		10	0d. Inside City Limits
	e Ma-f s	Director	Maryland Carroll Ha	ampstead			1 □ Yes 2 No
	th th	Jire	10e. Street and Number	10f. Zip Code	10g	. Citizen of What Coun	try?
	23a	le le	4230 Crystal Ct. Apt. 3C	21074	7-6	U.S.	Α.
	be filed within 72 hours after death with the Maryland stal Hyglene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	<ol> <li>Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto</li> </ol>	pecify Yes or No-	14. Race - America Black, White, e	
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yland	ntal hed of	Be	17. I dillet 3 Name (1 list, Middle, Last)	To, Mother's Name	ne (First, Middle, Ma	iden Surname)	
Ĕ	hould be d Menta narked natic ev	ဠ	400 Informantia Nama (Dalatianahia /Tima China)	Susan	Kay Ropa	ach	
Mar	d 2 sl th an 7 Is r traur			lailing Address (Street and Number or Ru			21130
ص ص	1 an Heali em 2		Susan K. Ropach - mother 102	l Glyndon Dr. Ap		Ceisterst	
altimore,	ages or or o		I Bunai 2 X Cremation 3 D Removal from State	isposition (Name of crematory or other place)		,	•
	rt. Per rtant rtant			Crematory Oct.			
g	permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 Is marked any Injury or other traumatic evonce.		21. Signature of Funeral Service Licensee	22. Name and Address of Facility E C	khardt E	Tuneral C	hapel P.A
			J. Henth Ceshones	11605 Reisterst			
		8 1	23a. Part1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.		_		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)  a.   **TMST**  a.   **TMST**  *	ATIC SQUAMOUS CELL	foraus	CANCER	
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ă	death e atten d for u	ciar	in the past 12 months?	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of deliver Month	ny Day Year
j	that the death certifii ed by the attending I detached for use as	Physician/Me	1 Yes 2 No 4 Pregnant at time of death 9 Unknown 9 Unknown	on other (specify)			
<b>T</b>	The law requires that the site has been signed by the bage 2 should be detache		Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause given in Part I.	23e. Did tobar	co use contribute to the	e cause of death?
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						d? death? No 1 ☐ Yes	2□No
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5	Phys this al dii	2	1  Yes 2			e 6 ☐Other (Specify	)
	r Attending Physician: The laver death, rector: After this certificate has by the funeral director, page 2 by	Certification:	1 ☑Natural 5 ☐ Pending (Month, Day Year) Inju	ry Work?	28d. Describe how	Injury occurred	
JIVISION	ttend death stor: the	cat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be determined determined	M 1 Yes 2 No	205 1 (21)		
2	or A after Direct in by	it.	4 Homicide determined building, etc. (Specify)	Street, factory, office	City or Town, S	et and Number or Rural State)	Houte Number,
_	spital ours erai filled		29a. Certifier 1 Certifying Physician: To the best of my knowledge, d	eath occurred at the time, date and place	and due to the cau	Po(s) and manner so at	atad
	To the Hospital or Attending Physician: whith 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director,	Medical	(Check only one)  2 Medical Examiner: On the basis of examination and/o and manner stated.	r investigation, in my opinion, death occur	rred at the time, date	and place, and due to	the cause(s)
	ompl	Me	29h Signature and title of certifier	29c. License number	29d	Date signed (Month, L	Day, Year)
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	$\cap$		30. Name and address of person who completed cause of death (Item 23a) (Ty)	ne Print)		10001	COD +
	<i>→</i>		Arimish Paulua no 22 5. anot	pe, Print)  Docces  pe, Print)  De ST Re 95004	. 1.	4	0 120
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item State of Maryland Dengton Health and Mental Hygiene Certificate of Death

Reg. No. Reg. No 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 3Ö - 200 /Medical 4a. Facility Name (If not institution, give street and number) 4b. Cify, Town, or Location of Death 4c. County of Death Examiner Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Months Min 1 ☐ M 2 🗙 F Director ce of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or Items 23a or 28a-f show edi al Ex miner must be notified at Director 1 Yes 2 □ No timore 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Funeral Wood Creek Cou LSA filed within 72 hours after death Was Decedent Ev. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) - American Indian 11. Marital Status Black, White 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify δ 3 Widowed 4 Divorced Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. ary (0-12) College (1-4or 5+) Department of Health and Mental Hygien Important: If item 27 is marked other the any injury or other traumatic event, the item 2000. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Ma 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 107 4 Donation 5 Dother (Specify) 61 of Funeral Service 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician ai Rat disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Myocardial Infarct Sequentially list conditions, if any cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed physician and the burial-trans Due to (or as a consequence of) P.O. Box 68760, nding physician Physician/Medical use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant atten in the past 12 months? 3 Ectopic pregnancy ò Month Day Vear 5 ☐ Other (specify). signed by the at I be detached fo 4□Pregnant at time of death 9 Unknown 9 Unknows Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy perform Vital 1☐ Yes Physician: funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 No Hospital: Other: Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home Residence 6 Other (Specify) 0 After this 28a. Date of Injury (Month, Day Year) 27. Manner of Ceath 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Hospital or Attending 1 🖾 Natural 5 Pending investigation Injury after death. 1 ☐ Yes 2 ☐ No 2 ☐ Accident the 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)
October 5, 2007 m.D 0550 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) 333 alvert N Jal D'mare te filed (Month, Day, Year) legistrar's Signature State OCT 0 5 2007 Registrar

DHMH 17 Rev 1/2001

			For State	State of Maryla				id Mental H	ygien	е	
		Ţ,	Registrar		Cei	rtificate of	Death		Reg. No	2007	32014
	Physici	an	1. Decedent's Name (First, Middle, La: Joan Louise Rambo	st)				2. Date of Month		2,2007 Year	3. Time of Death
	/Medic		4a. Facility Name (If not institution, give	etrant and number)		4b. City, Town, o	r Logation of C	Octob		C. County of Death	2:00 P. M
<b>)</b>	Examin	er	2518 Stone Mill R				kesvill			altimore	
S	Funeral		5. Social Security Number 6. S	ex 7. Age (In yrs	s. last birthday)	If Under 1 Year	If Under 24	Hrs. 8. Date of I	Birth		
	Director		217-52-2735	□M 2ÅF 54	Yrs.	Months Days	Hours	Min. (Month, March	17,	1953 Balt	place (State or Foreign intry) LIMORE, MD.
	pu »		Usual Residence of Decedent  10a. State 10b. County	100.0	ity, Town or Lo	cation					10d. Inside City Limits
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	death ms 2 r mus	Funeral	11. Marital Status	12. Was Decedent Ever in I	J.S. 13.	Was Decedent of H	lispanic Origin	n? (Specify Yes or Puerto Rican, etc.)	No-	14. Race - Ameri	
-0030	72 hours after death with the Maryland natural", or items 23a or 28a-f show dical Examiner must be notified at	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		1 ☐ Yes 2XX No	Specify:	rueno Rican, etc.)		Black, White	, etc. Vhite
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ž	hould d Mei marke	ပ္	James Edward Ramb  19a. Informant's Name/Relationship (		10h Mailir	na Address (Street		. Louise		Lams or Town, State, Zi	in Codo)
<u> </u>	nd 2 s Ith an 27 is		Mrs. Jean R. Hank			3 Hillen				le,Maryla	·
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altimo	Page nent o nt: if		1 ☐ Burial 2 ☒ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif	The Hovar Roll State	ans Fun	eral Cha	pel //	714107	F	orest Hil	ll,Maryland
Dalt	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at one.		21. Signature of Funeral Service Licer	gair, Dr	Pě	Name and Address aceful A 325 York	îternat Road	ives Fun Timoniu	erala m.Mai	&Cremation	on Ctr.,P.A 21093
Ď.	(AAA)	17.5	23a. P. F. Er er he di A se, or com	plic tit ns that caused the dea one ause on each line.	ath. Do not ent	er the mode of dyi	ng, such as ca	rdiac or respirator	arrest,		Approximate
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N I Cal			25. Was case referred to medical				26 Place of	1  Ye  Death (Check on	_	lo 1 □Yes	272 No
	ysicis is cer direct	To Be	examiner?	Hospital: 1 ☐ Inpatient 2 [	☐ ER/Outpatier	nt 3 DOA Oth	ner:		/	6 □Other (Spec	ifv)
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DIVISION	lor Att after d Direct in by	Certification:	3 Suicide 6 Could not be determined	28e. Place of injury - At building, etc. (Spec	home, farm, str cify)	eet, factory, office			n (Street a Town, Sta	and Number or Rui te)	ral Route Number,
	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certification of the Funeral director, to the funeral director, completely filled in by the funeral director,	Medical C	29a. Certifier (Check only one)	ysician: To the best of my kr niner: On the basis of examir and manner stated.	nowledge, deat nation and/or in	h occurred at the ti vestigation, in my	ime, date and popinion, death	place, and due to to occurred at the tin	he cause( ne, date a	(s) and manner as nd place, and due	stated. to the cause(s)
	o the	Mec	29b. Signature and title of certifier	and manner stated.		29c. Licens	se number		29d. D	ate signed (Month	, Day, Year)
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	17		30. Name and address of person who	6 7							
	12		William Shar	For 10753	F=111	Red H	415	Whenl	len	10 510	73
	Sta		31. Date filed (Month, Day, Year) OCT 0 5	completed cause of death (Ite from 17753 2007 32. Registrar's Sign	nature	barles					
	Registr	ar	00100	The state of the s	-						

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) Date of Death 3. Time of Death Year **Physician** 6:05PM Gregory Kochester Sept 200 20 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** VA Medicul Center Bultimore NIA Baltimore If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign **Funeral** Days 1 4M 2□ F 213-64-1330 **Director** Usual Residence of Decedent filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show edical Examiner must be notified at 1 ☐Yes 2 ☐ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race · American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. Specify: /3/ac/c þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hyglene. Important: If item 27 is marked other than "na any injury or other traumatic event, the Medicone. (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) aborer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Be 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 □ Cremation 3 □Removal from State Forest Vet Cem. 4 ☐ Donation 5 ☐ Other (Specify) 10-11-2007 21. Signature of Funeral Service Licens 23a. Part1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or he a consequence of): **Physician** Meningitis /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner law requires that the death certificate be execut sician and burial-tran Due to (or as a consequence of): Records, P.O. Box 68760 physician Physician/Medical the attending If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy for Month in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕱 Ûnknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ▼ No 24a. Was an certificate has autopsy performe 1 Yes 2 Division or Vital To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No P 1 npatient 2 ER/Outpatient 3 DOA funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 1 Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 21212 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bultomore MD 2120 Greene

DHMH 17 Rev 1/2001

State Registrar

31. Date filed (Month, Day, Year)

**ORIGINAL** 

Registrar's Signature

07-07688 Myrtle Scott Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

yrtle Scott		State of Marylan For State		tment of ificate of		o Mental H	rygierie Reg	. No. 2	007	3201
Physician	/ 1	egistrar . Decedent's Name (First, Middle,Last)		Cook			2. Date of Death Month October 1,		- 1	Time of Death 1755 hrs
ledical Examine		Myrtle  la. Facility Name (if not institution, give street and numbers)	per)	Scot		Location of Deat		4c. County of		
		916 Pennsylvania Avenue			Baltimore				NA	
Funeral Director	- 1	5. Social Security Number 6. Sex 7. 218–62–5093 1 M 2 XF	Age (In yrs. las	-	If Under 1 Yea Months Day				Foreign	ry) Md.
Á	-	Jsual Residence of Decedent  10a, State 10b, County	10c. City.	Town or Locati	on				10	Od. Inside City Limits
d now any		Md. NA	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	Baltim					1	X Yes 2 No
Aaryland 28a-f show 3 at once.	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of Wi	nat Country	?
with the Maryland ms 23a or 28a-f sho		916 Pennsylvania			2121				SA	- Indian Block
, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland ealth and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f she traumatic event, the Medical Examiner must be notified at once		11. Marital Status 12. Was Deceded Armed Ford	es?	6. 13. Wa	s Decedent of Hi es, specify Cuba	spanic Origin?(S n, Mexican, Puert	Specify Yes or No- to Rican, etc.)		e, etc.	n Indian, Black,
ter dea	<u> </u>	3 Widowed 4 Divorced If Yes, Give Year	2 X No	1	Yes 2 X No	specify:		Specify:	Blac	k
ours af	<u> </u>	15. Decedent's Education (Specify only highest grade				tion (Give kind of e. DO NOT use re		16b. Kind of Bu	usiness/Ind	ustry
1215-0036 Id be filed within 72 hou fental Hygiene. Thanked other than "matevent, the Medical Exa	Completed	Elementary/Secondary (0-12) College (1-4)  12th grade 4 yrs.	or 5+)	Die	abled			NA		
d with ygiene other the Mec	틹	12th grade 4 yrs.  17. Father's Name (First, Middle, Last)		DI	abied	18.Mother's Nan	ne (First, Middle, M		e)	
21215-0036 Uld be filed within 7 Mental Hygiens event, the Medica	8	Paul	Bra	aswell		Magud			rockr	
D 21 should and Me 7 is ma	우	19a. Informant's Name/Relationship (Type, Print)  Maxie Franklin-Son		17			Rural Route Numer, Baltime			
mad 2 shc and 2 shc lealth and tem 27 is traumati	-	20a. Method of Disposition		Place of Dispos	sition (Name of ce		Date	20c. Location	- City or To	
nore		1 X Burial 2 Cremation 3 Removal from 4 Donation 5 Other Specify:	II State	rematory or ot	ner place)	10	-8-07	Dunda	ılk, M	id.
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 Department of Health and Mental Hygiene Important: If item 27 is marked other than injury or other traumatic event, the Medical	t	21. Signature of Funeral Service Licensee		22.1	Name and Addres	ss of Facility	March F.	H. East	Md.	21202
	4	23a. Part I. Enter the disease, of complications that cal	used the death				re., Balt			Approximate Interval
Physician Medical		failure. List only one cause on each line.								Between Onset and Death
xaminer	- [	or condition resulting in death)  a. Type tensive Due to (or as a condition resulting in death)								
	١,	Sequentially list conditions, if any, leading to immediate b.  Due to (or as a condition)	consequence of	f):						
	ايّ	cause. Enter Underlying Cause								
ted T	Exa	events resulting in death) Last  Due to (or as a of	consequence o	r):						
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Box 68760, edeath certificate be the attending physicial for use as the burind for use a	/Mec	and that I are to the command to the	utcome of preg		etal death 3	Ectopic preg	nancy	23d. Date of Month	of delivery Da	ay Year
Sox 6876 death certificate e attending phy I for use as the	cian	past 12 months?	ant at time of de	ath -	ther (Specify)					•
Boy he death the att	≥ા	1 Yes 2 No 9 V Unknown 9 Unknow		aculting in the	underlying cause	given in Part I	23e. Did to	bacco use con	tribute to th	ne cause of death?
P.O. es that the igned by	٦	Part II. Other significant conditions contributing to Heart Disease, HTN, Asthma and CH		esulting in the	underlying cause	given in Fait i.				ably 4 🗸 Unknown
ords, F w requires to seen sign should be	Completed	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,					24a. Was			opsy findings available
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Vita hysicis this ce	To Be	1 V Yes 2 No	npatient 2	ER/Outpatier		1	rsing Home 5	Residence 6		Scene
n of ding Ph	삥	27. Manner of Death  1 Natural 5 Pending  28a. Date of (Month,	of Injury Day,Year)	28b. Time of	· · ·	jury at Work? Yes 2 No	Zou. Describe	now injury occi	iii Gu	
Sion Atten	ertification:	2 Accident Investigation 28e. Place	e of Injury - At h	ome, farm, str	eet, factory, office	e building, etc.			nber or Rur	al Route Number, City
Division pital or Attencours after death teral Director:	erti	4 Homicide determined (Specify)					or Town, S			
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	Medical C	29a. Certifier (Check only one) 2 Medical Examiner: On the basis of and manner st	of examination a	lge, death occ and/or investig	urred at the time, ation, in my opini	date and place, a on, death occurre	and due to the caused at the time, date	and place, and	d due to the	cause(s)
To To S	Me	29b. Signature and title of certifier		-		nse number			,	th, Day, Year)
		Homek grithall, mel)			0.0	C.M.E.		October :	5, 2007	
2		30. Name and address of person who completed cause Pamela E. Southall, MD Assistant I	e of death (Iter Medical Exa	<sup>n 23a)</sup> aminer 1	11 Penn Stre	et, Baltimore	e, MD 21201			
St	ate	31. Date filed (Month, Day, Year) 32 Re	gistrar's Signat		de					
Regist		0 ~ 0007 Mile	Estad La	" AST	100					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Theodore Edward Szymanski OCTOBER 2007 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Saint Joseph Medical Center Towson Baltimore 7. Age (In yrs. last birthday) 83 vrs 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 08-12-1924 Birthplace (State or Foreign Country) 217-20-0341 1**⊠**M 2□F Months Days Hours Min Maryland Usual Residence of Decedent 10c. City, Town or Location 10a, State 10b. Count 10d. Inside City Limits MD Baltimore Towson 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1617 Myamby Road 21286 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2K Married 1 X Yes 2 □ If Yes, Give Year or Dates: 2 □ No Specify: White 1. Yes 2 No Specify. 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Internal Auditor <u>Telephone</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Vincent Szymanski Lillian Lewandowski 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gertrude Szymanski/Wife 1617 Myamby Road, Towson, MD 21286 20b. Place of Disposition (Name of Duraney Crematory or other place)
Duraney Valley
Memorial Gardens 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 10-8-2007 Timonium, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fungral Service Licer 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Rd., Towson, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) SHOCK MIN Due to (or as a consequence of) RUPTURED ABDOMINAL AORTIC ANEURYSM Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last HOURS METASTATIC RECTAL CARCINOMA YEARS Due to (or as a consequence of) IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 1 Tes 3 Probably 4 ☐Unknown 24a. Was an Were autopsy findings available prior to completion of cause of autopsy perforn 2 No 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient
Date of Injury 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 2 Accident (Month, Day Year)

Examine be executed burial-tran attending physician Box 68760 Physician/Medical the P.0. the by signed t Records, Completed by ge 2 should certifica e has à Division or Vital Be ٩

**Physician** 

/Medical

Examiner

funeral director, After this Certification: Hospital or Attending death. within 24 hours after death To the Funeral Director: filled in by

**Physician** 

/Medical

Examiner

Director

Funeral

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Completed

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**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heath and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at

Maryland 21215-0036

Baltimore,

the

State Registrar

Medical

29b. Signature and title d U

6 Could not be determined

3 Suicide

29a. Certifier

4 Homicide

(Check only one.

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

29c. License number D35453

1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basic of examination and/or investigation in a stated.

1 ☐ Yes 2 ☐ No

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

TNDA BARR M 31. Date filed (Month, Day, Year) 2007 OCT 0 5

ER

TOWSON, MARYLAND 21204

			For State Registrar	Stat	e of M	aryland	-	artment <i>rtificate</i>		alth and M eath	1ental Hy	/gien Reg. N	ZUU	7	320	18
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j.	/Medic Examin		4a. Facility Name (If not institution					4b. City, T	Town, or Lo	cation of Death			c. County of De	ath	0.521111	
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	Funeral		Social Security Number	6. Sex	7. Ag	ge (in yrs. la			Year II	Under 24 Hrs.	8. Date of B	irth	9 B		e (State or Fo	oreign
	Director		227-76-0659	1 □ M 2🛚	] F	56	Yrs.	Months	Days	Hours Min.	April				ginia	
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	nd 2		Vergie Mose/	Sister			Р.	O. Box	x 130	3, Washi	ington	Grov	ve. Mar	vlai	nd 2088	30
<u>o</u>	is 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hygiene. Item 27 Ie marked other then "natural", or Itema 23e or 28e-f ehow other treumatic event. The Medical Examinar must be notified at		20a. Method of Disposition			20b. Pla	ce of Dispo	sition (Nam	e of		Date		Location - City			
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Baltimore,	mit. Sertm Sorts inju		21. Signature of Funeral Service	Licensee	1.		2	2. Name and	Address of	of Facility Rol	pert_A.	Pur	phrey	Fune	eral Ho	ome/
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je J	/Medical		disease or condition resulting in death)	a	e to (or as	a conseque	ence of):		~	1)	1		,	+		//
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0	w requires that the death certif been signed by the attending should be detached for use es	IF FEMALE: 23b. Was decedent pregnant in the past 12 growths? 1   Yes 2   No 9   Unknown   Yes 2   Unknown   Yes 3   Unknown   Yes 3   Unknown   Yes 3   Unknown   Yes 4   Unknown   Yes 5   Unknown   Yes 6   Unknown   Yes 6   Unknown   Yes 7   Unknown   Yes 8   Unknown   Yes 9   U												-,		
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	To the Hospital or Attending Physician: within 24 hours after death. To the Funaral Director: After this certific completely filled in by the funeral director.	Medical	(Check only Medical one)	Examiner: On	the basis of	of examinati	on and/or in	vestigation,	in my opini	ion, death occur	red at the time	, date a	nd place, and d	lue to th	e cause(s)	
	Mithin Fo th	Me	29b. Signature and title of certifie		1/2				License n			29d. D	ate signed (Mo	onth, Da	y, Year)	
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	23		30. Name and address of person	why completed	cause, ol	death (Item	23a) (Type.	Print)	-		1 )		1 2	, L	laid !	, 44
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2007

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** September 30, 2007 11:15 RM Chun Kil Sin /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Silver Spring Holy Cross Hospital | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | August 27,1918 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 ☐ M 2 🛣 F 89 Korea 212-98-5040 Yrs. Director Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Rockville a or 28a-f sh MarylandMontgomery 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 14207 Chesterfield Road 20853 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 TNo If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married 21215-0036 Asian 1 ☐ Yes 2 X No Specify: Completed by Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 6 Maryland 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any Injury or other traumatic event 18. Mother's Name (First, Middle, Maiden Surname) Be Ok Soon Kim Won Soon Sin ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code), 14207 Chesterfield Road, Rockville, Maryland 20853 Phillip Yu/Son Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other) 20a. Method of Disposition October 6, 20c. Location - City or Town, State cemetery, crematory or other place)
Parklawn Memorial
Park 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Rockville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2007 22. Name and Address of FacilityRobert A. Pumphrey Funeral Home Rockyille Inc /300 W. Montgomery Avenue, Rockville Maryland 20850 21. Signature of Funeral Service Licensee Logan Luhait M01498 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Respitory Arrest /Medical Due to (or as a consequence of): Examiner Parietal & Occipital Infarcts Sequentially list conditions, Due to (or as a consequence of) Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed burial-transit Intranchymal Bleed Due to (or as a consequence of) Physician/Medical for use IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Day Year 4□Pregnant at time of death 5 Other (specify) P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? or Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? page 2 No 1□ Yes the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No Hospital: P 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral. 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division 5 Pending investigation 1 🙀 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital within 24 hours a To the Funeral I 🔯 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) October 1, 2007 D65305 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Nabila Khan, M.D. 1500 Forest Glen Road, Silver Spring, Maryland 20910 31. Date filed (Month, Day, Year) 2. Registrar's Signature State Registra

DHMH 17 Rev 1/2001

			Please Type or Pri					-		-	
				larylan		artment of F		Mental Hy	giene	9	
			1 - State Registrar		Ce	rtificate of	Death	1	Reg. No	2007	32020
a, TT	Physici	an	1. Decedent's Name (First, Middle, Last)					2. Date of De Month	Da		3. Time of Death
	/Medic	al	William Dennis Sullivan,  4a. Facility Name (If not institution, give street and number			4h Oit Tour	.1	Octobe		2007	9:20 Р м
	Examin	er	Frederick Memorial Hospi				r Location of Death	l	40.	County of Death	-1-
- 4	Funeral				ast birthday)	Freder		8. Date of Bi	rth	Frederic	ilana (State or Foreign
	Director		220-74-4558 <sup>1⊠M 2□F</sup>	49		Months Days	Hours Min.	March Da	T'9 ear	958 Washi	ington, D.C
will be	P .		Usual Residence of Decedent	T							
	arylar show dat	_	10a. State 10b. County		, Town or L					1	0d. Inside City Limits
	he Ma Sa-f	Directo	Maryland Frederick	Fre	dericl						1 ☐ Yes 2 🛣 No
	with t	Ö	700 Toll House Avenue			10f. Zip Code 2170	1		_	tizen of What Cour	*
	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show ont, the Medical Examiner must be notitled at	Funeral	11. Marital Status 12. Was Decedent	Ever in III	S 13			noify Vac or N		ed State	
	fter d	Fun	Armed Forces	?	0. 10.	Was Decedent of H If Yes, specify Cub	an, Mexican, Puerto	o Rican, etc.)	,	Black, White,	
3	urs a al', o	þ	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:			1 ☐ Yes 2X No	Specify:			Specify: Whit	е
215-0036	72 ho natur ilosi i	Completed	15. Decedent's Education (Specify only highest grade completed)		16a. Dece	dent's Usual Occup	pation	lin =	16b. K	ind of Business/Inc	dustry
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7	lygier her th	Co	12		ETECI	LICIAN				structio	n
and and	be fil htal H sd otl	Be	17. Father's Name (First, Middle, Last) William D. Sullivan, Sr.				18. Mother's Nam			Surname)	
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Maryland 21	d 2 sl th an 7 is r traur		19a. Informant's Name/Relationship (Type. Print)	ı.1		ng Address (Street			-		,
a)	Heal Heal tem 2		William D. Sullivan, Sr./F. 20a. Method of Disposition	20b. P	lace of Dispo	osition (Name of	i	Date	20c. Le	e, Maryla ocation - City or To	nd 20852
<u></u>	ages ant of t: If it y or c		1 → Bunal 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)	C	emetery, cre Gate c	matory or other plai Theaven	ce) Octob 200	er 8,	Si1	ver Spri	ng,
Baitimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Licensee	Cei	metery	7 2. Name and Addre				yland Fun	owol Home
ñ	permi Depa Impo any Ir		John L. M.		F	Rockville	, Inc. 730	0 West	Mont	gomery A	eral Home
r			23a. Part1. Enter the disease, or complications that cause shock, or heart failure. List only one cause on each	d the death	n. Do not en	Rockville ter the mode of dying	ng, such as cardiac	or respiratory a	arrest,		Approximate Interval Between
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	重量量	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	s a consequ	uence of):						
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280	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	Physician/Medical	d								
X Q Q	nding use a	N/M	IF FEMALE: 23c. If yes, outcome 23b. Was decedent pregnant	e pf <u>pr</u> egna						23d. Date of delive	anv.
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	gned be de	by F	Part II. Other significant conditions contributing to death I		_		ren in Part I.	23e. Did	tobacco	use contribute to th	ne cause of death?
ecords,	equir	ted	END STAGE RENA				-	1 🗆	Yes 2	No 3□ Prob	ably 4 Unknown
ပ္ပ		Completed	HISTORY OF MULTIP	LE S	TRO	KES		24a. Was		24b. Were auto	psy findings available mpletion of cause of
	The cate has page	Con	DIABETES MELL	1705				perfe 1∐ Yes	ormed?	death?	2 □ No
N I	Physician: The law this certificate has braidirector, page 2 s	Be	25. Was case referred to medical examiner?  Hospital:			044	26. Place of Dea				
Ö	Phy ral d	۲: 2	1  Yes 2 No riospital: 1 1 mpati 27. Manner of Death 28a. Date of inj		ER/Outpatie	nt 3 DOA Oth	4 LINUISHIG H	ome 5 Resi		6 □Other (Specif	y)
0	ng fte ine	tion	1 Matural 5 Pending (Month, Da 2 Accident investigation	ay Year)	Injury	Wor	k? Yes 2∐No	Zou. Describe	now inju	ry occurred	
UIVISION	I or Attendiater death.  Director: A	fica	3 Suicide 6 Could not be determined 28e. Place of in	jury - At ho	me, farm, st	reet, factory, office		28f. Location (	Street ar	nd Number or Rura	I Route Number.
5	al or s affer il Dire	Certification:	4 ☐ Homicide determined building, e	tc. (Specify	1)			City or To	wn, State	9)	
	ospit: hours unera ly fille		29a. Certifier    Certifying Physician: To the best   Check only   2   Medical Examiner: On the basis	t of my know	wledge, deal	th occurred at the ti	me, date and place	, and due to the	cause(s	) and manner as s	tated.
	the H in 24 the Fo	Medical	(Check only 2 Medical Examiner: On the basis one) and manner s	or examinat tated.	tion and/or if	ivestigation, in my o	opinion, death occu	rred at the time	, date an	d place, and due to	the cause(s)
	To the Hospital or Attendi within 24 hours after death.  To the Funeral Director: A completely filled in by the fu	Σ	29b. Signature and title of certifier			29c. Licens				te signed (Month,	
1			me, mb			000	060417		10	0.3.5	(00)
	/		30. Name and address of person who completed cause of	death (Item 1	23a) (Type,	Print)	h				
	Sta	te.	Hemen SHAH, 65 c T. 31. Date filed (Month, Day, Year)  OCT 0 5 2007	rar's Signal	ture J	ounson	DV, F	vedevi	CŁ	MD 2	1702
	Registr		OCT 0 5 2007	مكر سيما	" So	sell!					
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07-07604 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Willie Edd Turner State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ Month Day Year September 27, 2007 1818 hrs Edd Medical Examiner Willie Turner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Baltimore County** 2913 Dunmurry Road Apt. A Dundalk If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Director 248-56-5888 Country) 1 XM 2 F 8-2-1939 S.C Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 Y Yes 2 No Md. Baltimore Dundalk Pages 1 and 2 should be filed within 72 hours after death with the Maryland Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 23a or 28a-2913 Dunmurry Rd. Apt. A 21222 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Funera 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, Armed Forces? White, etc. 1 Never Married 2 Married 1 X Yes Black Widowed 4 X Divorced If Yes, Give Yea Yes 2 X No specify: Specify \$ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) item 27 is marked other than "natur r traumatic event, the Medical Exam Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Laborer Raymond Builders 11th grade NA and Mental Hygiene. 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be Frank Sterling Mary Etta ۵ 19a. Informant's Name/Relationship (Type, Print ) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) NO. Teresa Turner Blackmon P.O. Box 611, Pembroke, N.C. Daughter Baltimore, MC permit. Pages 1 and 2 s 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 20a. Method of Disposition Date crematory or other place 1 X Burial 2 Cremation 3 Removal from State Important: injury or oth 10-5-07 Garrison Forest Vet. Owings Mills, Md. 4 Donation 5 Other Specify 22. Name and Address of Facility 21. Signature of Funeral Service Licensee March F.H. East War E. North Ave., Baltimore, 1101 Md 21202 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Approximate Interval Between Onset and failure. List only one cause on each line. /Medical a. Atherosclerotic Cardiovascular Disease Death Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit Physician/Medical X AMENDED 10/5/07 TT #12,perFH,g872, 10/5/07 TT attending physician or use as the burial -UNPENDED Records, P.O. Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant in the 3 Ectopic pregnancy Live birth Year Day Fetal death past 12 months Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown q Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 Yes 2 No 3 Probably 4 V Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of has b performed? death? certificate bector, page ✔ Yes 2 No 1 🗸 Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical 26.Place of Death (Check only one of Vital Be Hospital: 1 Other: Residence 6 V Other: Scene Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 1 Yes 28b. Time of Injury 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day, Year 28c. Injury at Work? Medical Certification: 1 V Natural Division 1 Yes 2 No To the Funeral Director: completely filled in by the Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f, Location (Street and Number or Rural Route Number, City Suicide Could not be (Specify) within 24 hours Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 😿 Medical Examination the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certi-29d. Date signed (Month, Day, Year) 29c. License numbe September 28, 2007 O.C.M.E. un 30. Name and address of person who completed cause of death (Item 23a) David Fowler M.D. Chief Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar ORIGINAL

DHMH 17 Rev 1/2001 **OCME 2006** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No.2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 29 29 09 2007 Jean P. Thomas 3:50 PM <sup>M</sup> 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Towson, Maryland Baltimore <u>Stella Maris Hospice</u> If Under 1 Year | If Under 24 Hrs. | 8. Months | Days | Hours | Min. | 8. Date of Birth (Month, Day, Year) 05/04/1923 Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 □ M 2 🛣 F England 578-46-7419 84 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2X No MD Baltimore Hydes 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13207 Bottom Road 21082 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 💆 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: 3 X Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 College (1-4or 5+) Retail Sales Salesperson 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Robert William Philipson Rose P. Richards 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Caroline T. Burall (daughter) 13207 Bottom Road - Hydes, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Dother (Specify) Arlington Nat'l Cem. 10/24/2007 | Arlington, Virginia 21. Signature of Funeral Sovice Licenses 22. Name and Address of Facility E. F. Lassahn Funeral Home, P.A. 11750 Belair Road - KIngsville, Maryland 21087 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) MULTIPLE MYELOMA Due to (or as a consequence of) Due to (or as a consequence of) Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death
4 □ Pregnant at time of death
9 □ Unknown 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 📉 No Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1□ Yes 26. Place of Death (Check only one)

**Physician** /Medical **Examiner** 

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Completed

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Certification:

Medical

**Physician** 

/Medical

**Examiner** 

**Funeral** 

Director

items 23a or 28a-f show ner must be notified at

Directo

Funeral

2

Completed

Be မ

2 should be filed within 72 hours after death with the Maryland and Mental Hygiene.

Baltimore, Maryland 21215-0036

Vital Records, P.O. Box 68760,

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, [uisease or injury that initiated events resulting in death) Last Examiner y physician and is the burial-trans Physician/Medical

IF FEMALE 23b. Was decedent pregnant

25. Was case referred to medical examiner? 1 ☐ Yes 2 X No 27. Manner of Death 1 Natural

1 🔲 Inpatient 28a. Date of Injury (Month, Day Year) 5 ☐ Pending investigation 6 Could not be determined

Hospital:

28c. Injury at Work? 28b. Time of 1 ☐ Yes 2 ☐ No Place of injury - At home, farm, street, factory, office building, etc. (Specify)

2 ER/Outpatient 3 DOA

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Other: 4 Nursing Home 5 Residence 6 X Other (Specify) HOSPICE

28d. Describe how injury occurred

29a. Certifier (Check only one)

2 Accident

3 ☐ Suicide

4 Homicide

1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number 193721

TIMONIUM, MD 21093

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2300 DULANEY VALLEY RD.

DR. TARIQ MAHMOOD 31. Date filed (Month, Day, Year)

32. Registrar's Signature

DHMH 17 Rev 1/2001

D

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician October 1, Robert Spencer Thorpe 2007 8:00PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner <u>Suburban Hospital</u> Bethesda Montgomery If Under 1 Year Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours Months Days Min. 1**X** M 2□ F Director 67 August 9,1940 <u>385-44-0721</u> Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural" ~ " any hipty or other traumatic event." 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Director Maryland Montgomery Bethesda 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 8601 Terrace Garden Way 20814 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married 1 ☐ Yes 2 No Specify: Completed by 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 5+Attorney Private Practice 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) æ မ Robert Spencer Thorpe Elizabeth Dresch 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anna S. Thorpe/ Wife 8601 Terrace Garden Way, Bethesda, Maryland 20814 20b. Place of Disposition (Name of cemetery, crematory or other place)
Montgomery
Crematorium Inc. 20a. Method of Disposition October 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 4, 2007 Bethesda, Maryland 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase. Inc. 7557 Wisconsin Avenue Bethesda, Maryland 20814-3501 21. Signature of Funeral Service Licenses M00335 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Left Subdural Hematoma disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Brain Contusion with Subarachnoid Bleed 6 days Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_ in the past 12 months? Month Day Year 4☐Pregnant at time of death 1 Yes 2 No 9□Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1⊠ Yes 2 No Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation Sept. 25, 20074:00PM M 1 ☐ Yes 2 X No 2 X Accident Tripped and fell 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide on street Wisconsin Ave. & Battery Lane

death certificate be executed attending physician The law requires that the Records, After this certificate Division or Vital Robert

been signed by the should be detached To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p Medical

and

State Registrar

nott

Me For

and manner stated.

29c. License number 20069

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Brajendra Nathmisra, M.D., 50 W. Edmonston Dr. #202, Rockville, Maryland 20852

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

29a. Certifier

(Check only one)

DCT 0 5 2007

32 Registrar's Signature

			For State Registrar	State of Ma		d / Depa		of He	alth ar		ntal Hyg	jiene •g. No 2007	32024
			Decedent's Name (First, Middle, Last)							2	Date of Dea Month		3. Time of Death
	Physici /Medi		Frederick Lee Ta	ylor								3, 2007	3:45 A <sup>M</sup>
	Examir		4a. Facility Name (If not institution, give s				_		ocation of	Death		4c. County of Dea	ith
			37 Hazelette Cou: 5. Social Security Number 6. Sex		e (In vrs	last birthday)	Conor		If Under 24	4 Hrs.   8	Date of Birth	Cecil	thplace (State or Foreign
	Funeral Director			M 2□F	63	Ven	Months				Date of Birth (Month, Day	Year) C 2, 1944 Ma:	ountry)
İ	D		Usuat Residence of Decedent									1) 13 1 10	10d. Inside City Limits
	I Z I 3-UU30 within 72 hours after death with the Maryland ene. then "natural", or items 23e or 28e-f ehow the Mudical Exercipe nust be notified at	_	10a. State 10b. County		10c. City	y, Town or Lo	cation						1 ☐ Yes 2 ☑ No
	the M	Director	Maryland Cecil  10e. Street and Number		Con	owingo	10f. Zip	Code				log. Citizen of What C	
	with 3a or 1	Ö	37 Hazelette Cou	rt				918				USA	· · · · · ·
4	death ms 23	nera		12. Was Decedent Armed Forces?	Ever in U.	.S. 13. \			panic Origin	n? (Specif	fy Yes or No- can, etc.)		
====	after or its	by Funeral	1 Never Married 2 Married	1 ∐Yes 2 🔯 i			1 ☐ Yes 2		Specify:	r dento mi	can, etc./	Specify:	16, 610.
1 1 8	hours ural',	q p	3 Widowed 4 Divorced	Year or Dates:			dent's Usua		ion				nite
1- ;	nation 72	ojete	15. Decedent's Educ (Specify only highest grade	completed)	- \	(Give	kind of won DO NOT us	k done du e retired)	iring most o	of working		100. Kind di busines.	sindustry
1 ) 8	Z I Z I D-UUSG d within 72 hours at glene. ar then "natural", or the Mudical Exem	Completed	Elementary/Secondary (0-12)	College (1-4or 5	o+)	Mecha	nic					Shoe Manu	facturer
		Bec	17. Father's Name (First, Middle, Last)					1				Maiden Sumame)	
1 -	VIATYIAN 12 should be hand Mental 7 is marked or raumatic eve	10	Asa Carr Taylor					12				Walter	7. 0.4.1
J.	IOCE, Maryland ges 1 and 2 should be file t of Health and Mental Hy If itam 27 ie marked oth or other traumatic event		19a. Informant's Name/Relationship (Ty) Allen Lee Taylor	oe, Print) / Son								r, City or Town, State,  MD 2191	
120	_ 5 = 0 =		20a. Method of Disposition	7 5011	20b. P	_ Place of Dispo	sition (Nam	ne of		Dat		20c. Location - City of	
8	SAITIMOFE, Dermit. Pages 1 a Department of Hee Important: If Itam any injury or othe		1 ☐ Burial 2 ☑ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	- 1	emetery, crer 1top S	•			0-5-6	07	Towson, M	aryland
2	Dalti permit. I Departm Importa		21. Signature of Fundal Service License	986	1						e, P.A		•
压。	n Baesa		Mul 201	my	_	1	1317 C	'okes	bury	Road	, Abino	gdon, Mary	land 21009
			23a. Part1. Enter the disease, or compli- shock, or heart failure. List only on	cations had caused se cause on each li	d the deat	h. Do not ent	ter the mode	e of dying,	, such as ca	ardiac or I	respiratory ar	rest,	Approximate Interval Between Onset and Death
	Physician /Medical	s į	Immediate Cause (Final disease or condition resulting in death)			CANO	CER						
	Examiner			Due to (or as	a conseq	uence of):							
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a conseq	uence of):				-			
12	cufed nd ransif	Examiner	that initiated events										
9	/60, Yellon and separated and		resulting in death) Last	Due to (or as	a conseq	uence of):							
ì	cate b	dical	• 0	l									
•	BOX 68 eath certifical affending phy for use as fh	by Physician/Medi	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome							-	23d. Date of d	elivery
	death death de affe	iciai	in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant a			□Ectopic pre □ Other (spe					Month	Day Year
	at the by the stache	hys	9 🗆 Unknown	9□ Unknown	_						T		
	DIVISION Of VITAI RECORDS, P.O. I or Attending Physician: The law requires that the dath death. Director: After this certificate has been signed by the Lin by the tuneral director, page 2 should be defached.		Part II. Other significant conditions con	tributing to death b	out not res	sulting in the u	inderlying ca	ause giver	n in Part I.				to the cause of death?  Probably 4 (Gunknown
	requi	Completed								_	24a. Was		autopsy findings available
	Hec Hecan	mpi								-	autop	sy prior to death?	completion of cause of
	tal In: Ti	0	25. Was case referred to medical						26. Place	of Death /	1 ☐ Yes Check only o		os 2 No
	ysich ysich is ceri	To B	examiner?	lospital: 1 🗆 Inpati	ent 2	ER/Outpatier	nt 3[] DO	Other	r			dence 6 Other (Sp	ecify)
	D D D D D D D D D D D D D D D D D D D		27. Manper of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	ury ay Ye <i>ar)</i>	28b. Time o Injury		8c. Injury Work			d. Describe h	now injury occurred	
	ISIO Itendi Ideath. Itor: A fhe fu	catl	2 Accident investigation 3 Suicide 6 Could not be	20a Ptaga of In	iuma At b	oma form et	M factor		es 2□N		of Location /	Street and Number or	Rural Route Number
	OIVI I or Al affer o Direc	Certification:	4 Homicide determined	28e. Ptace of In building, e	tc. (Specif	fy)	reet, ractory	, опісе		20	City or Tox		ibrar ridbio resissos,
	DIVISION Of VITAI HECONDS, P.O. BOX 68/6U, V. To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the aftending physician and completely filled in by the funeral director, page 2 should be defacted for use as the burial-transit	edical C			of examina							date and place, and d	
	o the	Med	29b. Signature and title of certifier				290	. License	number			29d. Date signed (Mo	nth, Day, Year)
	- S - 0	İ	· cunquisane	M				DI	6619			October 4	2007
	\		30. Name and a less of person who co	ompteted cause of	death (Iter	m 23a) (Type,	Print)	1.	<i>(</i> )		<b>D C</b>	Russia	
	\		C.VERGARA - So 31. Date filed (Month, Day, Year)	ARES Pagist	rar's Sign	o FF4	ANKLI	N S	SOUP	APRE	DIC.	FORLT IMORE	, NID1236
	Regist	ate trar	OCT 0 5 2007	Bloom	, B	Spa	e de						nth, Day, Year) 2, 2007 3, MD - 21236

DHMH 17 Rev 1/2001

ÖRIGINAL

Registrar DHMH 17 Rev 1/2001 SIMADY GROVE

OCT 0 5 2007

31. Date filed (Month, Day, Year)

9901

Registrar's Signature

ROCKVILLE NO 20850

#### ral", or items 23a or 28a-f show Examiner must be notifled at Director Maryland Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21212 910 Old Oak Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 XXIo 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 X If Yes, Give Year or Dates: 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXNo Specify: ģ 3 Widowed 4 Divorced "natural" Completed traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 12 should be filed within; h and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 4 Teacher-Librarian Baltimore COunty 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Dick Kellow Jessie Breckinridge ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s Health a Robert Venables 910 Old Oak Road Baltimore, Maryland 21212 Husband Item 27 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If Itel any Injury or oth XXBurial 2 ☐ Cremation 3 ☐ Removal from State Loudon Park Cemetery 10/8/07 Donation 5 ☐ Other (Specify) Baltimore, Maryland 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home, 6500 York Rd. Baltimore, MD 2 nature of Funeral S 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) ementin /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Lisease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): and Due to (or as a consequence of) 68760, 00 Physician/Medical the as attending ( Box IF FEMALE: M 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 10. in the past 12 months? 1 ☐ Yes 2 ☑ No 4□Pregnant at time of death 5 Other (specify) □Yes ed by the a P.O. 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Venable Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an certificate has autopsy 2 No 1∐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 2 0 funeral 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Rianeh Certification: Division To the Hospital or Attending within 24 hours after death. To the Funeral Director: After 1 Anatural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 🛘 🚾 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

1. Decedent's Name (First, Middle, Last)

Holly Hill Manor

5. Social Security Number

Usual Residence of Decedent

213-38-5634

10a. State

Blanche Kellow Venables

10b. County

4a. Facility Name (If not institution, give street and number)

6. Sex

**Physician** 

/Medical

Examiner

Medical

State Registrar

DHMH 17 Rev 1/2001

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, 'Year)

HoskMD

OCT 0 5 2007

30, Name and address of person who completed cause of death (Item 23a) (Type, Print)

402

32. Registrar's Signature

York

**Funeral** 

Director

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

21#301

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

4b. City, Town, or Location of Death

If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min.

Baltimore

7. Age (In yrs. last birthday)

10c. City, Town or Location

99

2. Date of Death Month

2007

Baltimore

1908 Tennessee

14. Race - American Indian,

Black, White, etc.

Specify: White

23d. Date of delivery

29d. Date signed (Month. Day. Year)

Towson MD

Day

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No

Month

4c. County of Death

USA

7:10

Birthplace (State or Foreign Country)

10d. Inside City Limits

Approximate Interval Between Onset and Death

O years

Year

1 ☐ Yes 2XXNo

 $A^M$ 

October 0

July 11,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 200 /Medical 4c. County of Death Examiner YIMOR. 9. Birthplace County (State or Foreign **Funeral** Days Months Director Usual Besidence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show ns 23a or 28a-f shov must be notified at 1 ☐ es 2 ☐ No **Funeral Director** 10g. Citizen of What Country? items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black White etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married 0 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Completed by 3 Widowed 4 ☐ Divorced "natural" the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Sylondary (0-12) College (1-4or 5+) 7 is marked other traumatic event, the 17. Father's Name (First, Middle, Last) UNK Be ( 18. Mother's Name (First, Middle, Maiden Surname) ဥ . Informant's Name/Relationship (Type. Print) (grand 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a daughte Counther Department of Health Important: If Item 27 any Injury or other tronce. Disposition 1 Burial 2 □ Cremation 3 □Removal from State 4 □ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens isease, or complications that caused the death. Do not enter illure. List only one cause on each line. 23a. Part1. Enter the disea shock, or healt failure Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of): physician at the burial Division or Vital Records, P.O. Box 68760, attending pl IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate has b irector, page 2 sl autopsy death? 1 ☐ Yes 1□ Yes 2□ No 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 🗌 Yes 2 No Certification: To 1 🔲 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1 ☐ Yes 2 ☐ No 24 hours after death. 2 Accident 6 ☐ Could not be 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier within 24 hor To the Fune completely f (Check only and manner stated. 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year)

State Registrar

31. Date filed (Month, Day, Year)

OCT 0 5 200

30. Name and address of person who completed cause of death (Hern 23a) (Type, Print)

trar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Physician pnie 2007 Marie 10 ams /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Avondale arkville timore If Under 1 Year | If Under 24 Hrs Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Days Hours Year) 1 M 2 **Y**F 9 Director Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show r than "natural", or items 23a or 28a-f shov the Medical Examiner must be notified at **Funeral Director** 1 Yes 2 No Itimore 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 9000 2123 Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 ☐ Yes 2 **2\***No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 P No Specify þ 3 ₩Widowed 4 Divorced white Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Department of Health and Mental Hygiene. Important: If Item 27 is marked other thar any Injury or other traumatic event, the M once. 8 tomemaker DWD. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Magness 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print Belair Court 732 Winterfield Joan 1-tcbbs 20b. Place of Disposition (Name of cemetery, crematory or other place)

Marchard Memoria 10-8-2007 Baltimore Md.

22. Name and Ad ress of Facility

Evans Funeral Chapel & Cremation Surs-Parkville

8800 Harford Road Parkville Md 21234 20a. Method of Disposition 1 Bal Burial 2 ☐ Cremation 3 □Removal from State 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee Lac Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician entra Minute /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Examine Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No cate has t page 2 s autopsy perform certificate 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ို 1 ☐ Yes 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural 2 ☐ Accident Injury 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fi 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and title of con 29c. License number 29d. Date signed (Month, Day, Year) Attending 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Newland Rd MI 21218 SchWARTZ 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. N.2 0 0 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Year 5:00 AM Williamson oreen 3 /Medical 2007 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death illage Baltimore 7. Age (In yrs. last birthday) rest 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral**  Birthplace (State or Foreign Country) 1 ☐ M 2 🖟 F Days Hours 88 Yrs. Director 214-14-4953 Mary lano Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ia or 28a-f show t be notified at Director 1 ☐ Yes 2 No Parkville altimore 10f. Zip Code 10g. Citizen of What Country? death with 23a Hpt 2211 DIVID USA 14. Race - American Indian, 2/234 Examiner must Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 1 Never Married 2 Married 5-0036 ò Be Completed by 1 ☐ Yes 2 ☑ No Specify: 3 Widowed 4 Divorced Specify. "natural", white the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Dentistr marked other Less Marylanc.

yermit. Pages 1 and 2 should be filed.
Department of Health and Menterimportant; if Item 27 is any Injury or off.
any Injury or off. other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 75 mann 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Spouse 8810 Walther Md altimore 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 0 4 ☐ Donation 5 ☐ Other (Specify) torest Itill 22. Name and Address of Facility Evans Funeral Chapel+Cremation Syrs-Parkville 8300 Harford Road Parkville Md 21234 21. Signature of Funeral Service Licensee Hau 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) emori hagic Stroke /Medical Due to (or as a consequence of) Examiner pertension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. has been signed by the attending physician ge 2 should be detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 3 ☐Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Bacteremie 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed? Yes 2 No this certificate 1□ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 No Hospital: 1 Tes Other: ို 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) in by the funeral 28a. Date of Injury (Month, Day Year) after death. 27. Manner of Death 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending Injury investigation М 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 THomicide within 24 hours a 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number ပ္ 29d. Date signed (Month, Day, Year) mone 0 D5864

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32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 13:40 PM Regina Eileen Whitcomb  $2\omega$ /Medical 4a. Eacility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner osedale are tal Conter timore If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) West Virginia Social Security Number . Age (In yrs. last birthday 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Min. 1 □ M 2 2 2 4 213-36-6297 68 Director 1938 Oct. Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2/7XNo Director Baltimore Maryland Essex 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 21221 U.S.A. "natural", or Items 23a 1446 Kent Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes **②**No If Yes, Give Year or Dates: 1 Never Married Married Baltimore, Maryland 21215-0036 1 ☐ Yes XXNo Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than, Elementary/Secondary (0-12) College (1-4or 5+) f Health and Mental Hygiene. Homemaker Own Home 10 Pages 1 and 2 should be filed v 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ursula Nolan Richard Sams ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1446 Kent Road, Baltimore, Maryland 21221 James Whitcomb (Husband) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition permit. Pages 1
Department of F
Important: If ite
any injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 10/04/2007 Bayview Crematory Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21 Signature of a uner diservice Lisensee 22. Name and Address of Facility
Bruzdzinski Funeral Home, P.A. 1407 Old Fastern Avenue, Essex, Maryland 21221 23. Full Ener the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ship, or heart failure. List only one couse on each line.

Immediate Cause (Final disease or condition residing in death)

a. Use to (or as a consequence of): **Physician** /Medical ue to (or as a consequence of): Examiner TENSION Sequentially list conditions, any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner certificate be executed burial-transit and Due to (or as a consequence of): P.O. Box 68760 attending physician Physician/Medical as the asn 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for 1 in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 2 🗆 No the detached 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, ð 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has page 2 autopsy performed 1☐ Yes 2☑No certificate 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 20 No 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA ္ this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manyrer of Death 28b. Time of 28d. Describe how injury occurred After 1 Certification: To the Hospital or Attending within 24 hours after death.
To the Funeral Director: After 5 Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident the 6 □ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 10 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month. Dav. Year) Conor

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State Registrar 31. Date filed (Month, Day, Year) CT 0 5 2007

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2007 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** 607AM WILLIAMS 01 2007 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner 4c. County of Death BALTI MORE UNIV OF MO MEDILAL If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days 1 ☐ M 2 🛛 F Yrs Director 213-66-9613 50 OCT. 9 1956 NORTH CAROLINA Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at Director 1 ☐ Yes 2 No MARYLAND HARFORD CO ABERDEEN 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 41 ROOSEVELT AVENUE APT C1 21001 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ∑XVo If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married altimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2XXXVo ģ Specify: BLACK 3 ☐ Widowed 4 ☑ Divorced Completed Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th grade FACTORY WORKER SEWELL PLACTISO INC 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be filk Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event 18. Mother's Name (First, Middle, Maiden Surname) Be ٩ CURTIS VAUGHAN NELLIE VAUGHAN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) CHERYL McCallum/Sister 334 BALTIMORE ST., ABERDEEN, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 255 remation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) METRO CREMATORY 10-09-07 BALTIMORE, MARYLAND 21. Signature of Funeral Service Licens 22. Name and Address of Facility WM C BROWN COMMUNITY FUNERAL HOME-HARFORD, P.A. 321 S PHILADELPHIA BLVD., ABERDEEN, MD 21001 1. Enter the disease, or comply tions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician SARLOIDOSIS disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Unlease of injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physician and for use as the burial-transi Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 ☑ Unknown detached 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Minknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

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2 D Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only

Division or Vital Records, P.O. Box 68760, Hospital or Attending Physician: within 2

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State Registrar

29b. Signature and title of certifier

LEON 31. Date filed (Month, Day, Year)

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and manner stated.

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32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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29c. License number

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29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene 2007 32033 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Dav Month Үөаг Physician Kathryn O. Warner 10:45 A<sup>M</sup> September 29, 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Shady Grove Adventist Hospital Rockville Montgomery If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months 1 ☐ M 2 🂢 F 91 1916 Virginia Director 577-01-8111 22. Usual Residence of Decedent the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "natural", or Items 23s or 28s-1 show way injury or other traumatic event, the Medical Examinant intentional angus. 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 □ No Director Maryland Montgomery Gaithersburg 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 303 Russell Avenue 20877 United States Funerai 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry National Institutes Elementary/Secondary (0-12) College (1-4or 5+) Of Health Grants Assistant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ( Armond W. Oakes Anna Snead 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David E. Bell/Nephew 25 Tamalpais Avenue, San Anselmo, CA 94960 20b. Place of Disposition (Name of competery, crematory or other place Parklawn Memorial Park t. 11, 2007 20a. Method of Disposition 20c. Location - City or Town, State Oct. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Rockville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Robert A. Rockville, Inc. 300 West Rockville, Maryland 20850 Pumphrey Funeral Home/ Montgomery Avenue 21. Signature of Funeral Service Licensee M01346 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Pneumonia 3 days /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, larry leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of or Attending Physiclen: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 No Month Year 5 Other (specify) 4☐Pregnant at time of death ed by the detached Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ sete has been signi page 2 should be 3 ☐ Probably 4 🗹 Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death?

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nerel Director: Af 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide To the Hospital or within 24 hours after To the Funeral Dir 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medicai completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier M.D D0065505 September 29, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D CHENG 4901 Medical Center Drive, Rockville, 32 Registrar's Signature 31. Date filed (Month, Day, Year) State Dist. OCT 0 5 2007 Registrar

			1 - For State Registrar	Si	tate of	Marylar	nd / Depa <i>Cei</i>	artme <i>rtifica</i>	nt of H	lealth a Death	and M	ental Hy	giene Reg. No.	2007	3203	4
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	/Medic		INEZ RACHEL	WOOD								OCTOBE	3,	2007	4:30 A	М
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Maryland	should be man		19a. Informant's Name/Relation	ship <i>(Type, F</i>	Print)		19b. Mailir	g Addre	ss (Street a			Route Number			, Zip Code)	
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	spita lours naral filled	C	29a. Certifier 1 Certifyi	ng Physicia	n: To the be	est of my kno	wledge, death	occurre	d at the tim	e date and	d place, a	nd due to the o	ause(s)	and manner:	hateta as	-
	P Ho	edical	(Check only 24 Medical one)	Examiner:	on the basi and manner	is of examina	tion and/or inv	estigatio	n, in my op	oinion, deat	h occurre	d at the time, o	ate and	place, and di	ue to the cause(s)	
	To the Hospital or At within 24 hours after d To the Funeral Direct completely filled in by	M	29b. Signature and title of certifie	er	-				c. License			i	9d. Dat	e signed (Moi	nth, Day, Year)	
			> DIL	- N	D				23	465	2	6	Tcto.	b1 3.	2007	
	$G_{j}$		30. Name and address of person	who comple	ted cause	of death (Item	23a) (Type,	Print)		2	1 4	-			16211	
	7		Sight /x	aswe	//	210	urth	AVI	nul	151/	AI	- Mu	141	unch	21014	
	Sta Registr		31. Date filed (Month, Day, Year,		39 Reg	istrar's Signa	ture									
			111:1 11 5	/ 1111 /	KINDO	ULI KI	A. C. C.									- 1

DHMH 17 Rev 1/2001

07-07183 Barbara Ash

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

arbara Ash		S I- For State Registrar	tate of Maryla		artment of rtificate of		d Mental H		eg. No. 20	07	3203
Physicia edical Examii	ın/	1. Decedent's Name (First, Middle,Last)  Barbara Jackson Ash  2. Da  Mc Se							Day Year er 15, 2007	17	ne of Death 15 hrs
**		4a. Facility Name (if not instituti Rt. 2 and Polling Hou	4b. City, Town, or Location of Death Harwood			4c. County of Death Anne Arundel					
Funeral Director		5. Social Security Number 227–62–1563	6. Sex	7. Age (In yrs. last birthday) 2XF 48 Yrs		If Under 1 Year Months Days			th(MM/DD/YYYY) § 1, 1959	9. Birthplace (State or Foreign Country)Virginia	
any		Usual Residence of Decedent  10a. State 10b. County		10c. City,	Town or Location	on					nside City Limits
th the Maryland 23a or 28a-f show notified at once.	ector	MD Anne  10e. Street and Number	Dunkirk	rk 1 1 Yes 2 Xi					Yes 2 X No		
56 n 72 hours after death with the N isn "natural", or items 23a or ical Examher must be notifie	y Funeral Director	6445 Meadowla  11. Marital Status  1 Never Married 2 XM  3 Widowed 4 Di	12. Was De Armed F 1 Yes vorced If Yes, Give Ye	12. Was Decedent Ever in U.S. Armed Forces?  1 Yes 2 X No If Yes only highest grade completed)  College (1-4 or 5+)  13. Was If Ye 14. Or Service of the complete of the compl		20754  s Decedent of Hispanic Origin? ( Specify Yes or Nies, specify Cuban, Mexican, Puerto Rican, etc.)  Yes 2 No specify:			U.S.A.  14. Race - American Indian, Black, White, etc.  Specify: White		
	Completed by	15. Decedent's Education (Sp Elementary/Secondary (0-12	ccify only highest gra College (			t's Usual Occupatost of working life	DO NOT use re		Communi	of Business/Industry nunity College oist Organization	
21215-0036 buld be filed within 7 Mestal Hygiene. marked other than ite eyent, the Medica	Be	17. Father's Name (First, Middle Daniel Wyer J 19a. Informant's Name/Relation	Jackson				<sup>18.Mother's Nam</sup> Doris C	. Maier	, Maiden Surname)		
주 명 등 등 등	To	Ernest Lawrenc 20a. Method of Disposition	e Ash, Jr	20b.	ınd) 644	5 Meadov	vlark Dr	ive, Dur		ryland	1 20754
Baltimore, permit. Pages 1 ar Department of Hee Important: If ite		1 Burial 2 X Crematic 4 Donation 5 Other 3 21. Signature	Specify:	TOTA State	ee Crem	atory		pt. 19, 2007 e Funera	Clinton	, Mary	land P.A.
Physician		Michael W. I. 23a. Part I. Enter the disease of failure. List only one caus		caused the death	812	5 Southe	ern Marv	land Bly	vd Owing	gs, MI	20736 proximate Interval tween Onset and
/Medical Examiner		Immediate Cause (Final disease or condition resulting in death)  a. Multiple Injuries  Due to (or as a consequence of):									
uted nd ransit	Examiner	Sequentially list conditions, if any, leading to immediate eauca. Enter Underlying Coece (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):  Due to (or as a consequence of):									
O, the exectsician are burial - t	edical	UNPENDED	AMENDED						Look But of a		
x 6876 h certificat tending phy use as the	ysician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 V Unknown  23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 5 Other (Specify) 9 Unknown								Year	
Is, P.O. Bo. puries that the deat en signed by the at all the detached for the bed detached for the signed by the signed by the signed by the signed by the signed for the	ted by Phy	Part II. Other significant cond	itions contributing	to death but not i	resulting in the u	inderlying cause	given in Part I.		tobacco use contribu	Probably	
of Vital Records, ng Physician: The law require this certificate has been si neral director, page 2 should b	Completed	25. Was case referred to medic				26 Place	e of Death (Chec	auto perfe 1 <b>V</b> Yes	psy pri ormed? de		etion of cause of
Vital hysiclan this cert	To Be	examiner? 1 ✓ Yes 2 No	Hospital: 1	Inpatient 2	ER/Outpatient	3 DOA	Other Nurs	ing Home 5	Residence 6		ne
ion of tending Ph death.	ation:		nding Sep 15	e of Injury th, Day Year) ), 2007	28b. Time of li 1658 hrs	1	ry at Work? Yes 2 ✔ No	Driver auto	how injury occurred auto collision		2 1 = 0
Division  Plospial or Attendin  124 hours after death.  e Funeral Director; A	Certification: To	3 Suicide 6 Could not be determined (Specify) Major Road / Highway						28f. Location (Street and Number or Rural Route Number, City or Town, State) Rt. 2 and Polling House Road , Harwood, MD			
To the Howithin 24 h To the Fun Completely	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  (Check only one)  Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)									
	2	and 2				O.C.M.E.			September 16, 2007		
5			sistant Medical	Examiner	111 Penn S	Street, Baltim	ore, MD 212	01			
St Regis	tate trar	31. Date filed (Month, Day Yea	Server 32. F	Registrar's Signat	perte						

			1 - For State Registrar	State of M	laryland /		irtment of H <i>tificate of L</i>		,	giene Reg. No. <b>2</b>	107	32036	
Physician /Medical			1. Decedent's Name (First, Middle, Last)						Date of Death     Month Day Year			3. Time of Death	
			WIDDIAM - ADDIT, OK.				4b. City, Town, or Location of Death			ber 21	2007 tv of Death	04:55A M	
	Examir	ner	Shady Grove Ad				Rockvi				iy or Dealin Iontqoi	merv	
	Funeral Director		5. Social Security Number 6. 223-66-2293		ge (In yrs. last b	vrs.	If Under 1 Year Months Days	_	der 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace Country)		place (State or Foreign		
	and ow t		Usual Residence of Decedent  10a. State 10b. County		10c. City, To	wn or Lo	cation				1	I 0d. Inside City Limits	
e, Marylan	Maryl -f sho fied a	by Funeral Director	Md. Monto	gomery	Roo	ckvi.	lle					1 ☐ Yes 2 🕱 No	
	h the or 28a e noti		10e. Street and Number				10f. Zip Code		10g. Citizen of W		What Coun	hat Country?	
	th wit		1902 Rockland	Avenue				20851		Unit	ed St	ates	
	be filed within 72 hours after death with the Marylar Ital Hygiene. do other than "natural", or fiems 23a or 28a-f show event, the Medical Examiner must be notified at		11. Marital Status  1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	12. Was Deceden Armed Forces 1  Yes 2 K If Yes, Give Year or Dates:	? No		Vas Decedent of Hi f Yes, specify Cuba I □ Yes 2 1 No	ispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)	Spec	ace - Americ ack, White, o		
	72 hc 'natui dical	eted	15. Decedent's E (Specify only highest gi	College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired)  Safety Director			rina	16b. Kind of I	b. Kind of Business/Industry  Roofing Company		
	vithin ne. han "	To Be Completed	Elementary/Secondary (0-12)						9	D 6			
	Hygi Hygi ther nt, t		12 17. Father's Name (First, Middle, Las	1.		5	arety Dir	18. Mother's Name	e (First Middle			ompany	
	uld be Aental rked o		William -	Alley, Sr	•			Ollie	Mae	Akers	•		
	d 2 shorth and No. 7 is material		19a. Informant's Name/Relationship Helen E. Alley		19		g Address (Street a					O851	
	0 0		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐  4 ☐ Donation 5 ☐ Other (Spec				sition (Name of natory or other place		Date 6/07	20c. Location	-	own, State	
Balti	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service Lice		/	22	Name and Address Muriel H				Md.	20882	
	Physician /Medical	resulting in death) a.									Approximate Interval Between Onset and Death 3 Hours		
Division or Vital Records, P.O. Box 68760,	Examiner	Examiner		Due to (or a	Due to (or as a consequence of):								
	rted sit		Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events	b. Due to (or as	b. Due to (or as a consequence of):								
	ificate be executed g physician and as the burial-transit	edical Exar	that initiated events resulting in death) Last	C. Due to (or as a consequence of):									
	# ose	Medical Certification: To Be Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 5 ☐ Other (specify) Month							ery Day Year		
	quires that n signed b ild be deta		Lung Cancer Diabetes Heart Failure									. /	
	ne (aw requin has been si ge 2 should I		Hypertension 24a. Was an autopsy performed? deatl							. Were auto prior to cor death?	ppsy findings available impletion of cause of		
			25. Was case referred to medical							1 ☐ Yes	2 No		
	lysicia is cert direct		examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA			t 3 DOA Othe	26. Place of Death (Check only one) ther: 4 □ Nursing Home 5 □ Residence 6 □ Other (S			ther (Specif	f <sub>V</sub> )	
	ing After		27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of In (Month, D	28a. Date of Injury (Month, Day Year) 28b. Time of Injury					Describe how injury occurred			
	e Hospital or Attend n 24 hours after death. te Funeral Director: A bletely filled in by the fi		3 Suicide 6 Could not 4 Homicide determined	be 28e. Place of in	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
	To the Hospit within 24 hours To the Funers completely fille											tated. o the cause(s)	
	To th within To th comp		29b. Signature and title of certifier		29c. License number				29d. Date signed (Month, Day, Year)				
			D 58681 Sep						Septem	ber 2	1, 2007		
Y	0		30. Name and address of person who	c, M.D.	9901	Med	ical Cent	er Drive	, Rockv	ille, M	id. 2	0850	
	Sta Regist		31. Date filed (Month, Day, Year) SEP 2 4 2	2007 32 Regis	trar's Signature	4	enter!						

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.2 2. Date of Death Date Month 1. Decedent's Name (First, Middle, Last) **Physician** enne 0 6 -200 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Salisbur Wicomico Hospice If Under 1 Year If Under 24 Hrs Social Security Number 7. Age (In yrs. last birthday, Birthplace (State or Foreign
Country) Date of Birth (Month, Day, Year) **Funeral** Days Months 1**X** M 2□ F Hours 67 216-38-9398 Director 03/02/1940 NORTH CAROLINA Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County r 28a-f show notified at show 10d. Inside City Limits 1 ☐ Yes 2 No Director MARYLAND WICOMICO **PARSONSBURG** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or 21849 33120 SHAVOX ROAD U.S.A. Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 M Yes 2 □ No ff Yes, Give U.S.C.G. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian. Black, White, etc. filed within 72 hours after 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify 2 WHITE 3 ☐ Widowed 4 ☐ Divorced Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) CONTRACTOR OWNER/OPERATOR 12 Health and Mental Hygi em 27 is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ould be fi HENRY THOMAS AINSWORTH MARY BLANCHE ROBINSON traumatic 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any Injury or other tra MADELINE BOWDEN AINSWORTH **SPOUSE** 33120 SHAVOX ROAD, PARSONSBURG, MD 21849 Pages 1 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 Removal from State 5 Other (Specify) 4 ☐ Donation JOHN W. TAYLOR CEMETERY 09/20/07 TEMPERANCEVILLE, VIRGINIA 21. Signature of Funeral Service License 22. Name and Address of Facility WILLIAMS FUNERAL HOME, 25046 PARKSLEY ROAD, PARKSLEY, VA 2342 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Metestatic **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, feading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): be executed burial-tra Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. attending physician Physician/Medical the IF FEMALE: If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 ☐ Fetal death 3 □ Ectopic pregnancy ō in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Dav 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a detached t 9□ Unknown 9 Unknown signed by t I be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ been si 1 Yes 217 No. 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy perform director 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 Other (Specify) PEZ No 1 Tyes Certification: To Inpatient 2 □ ER/Outpatient 3□ DOA this funeral 27. Manner of Death Date of Injury (Month, Day Year) 28b. Time of After 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 5 ☐ Pending investigation Naturaf Injury death. Accident 1 ☐ Yes 2 □ No within 24 hours after death To the Funeral Director: completely filled in by the 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide The Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Z Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number ပ Name and address of person who completed of e of death (Item 23a) (Type, Print)

Registrar

State

31. Date filed (Month, Day,

Year

24

2007

ORIGIN

rar's Signature

ORIGINAL

DHMH 17 Rev 1/2001

Registrar

UCT 0 5 2007

			For State Registrar	State	of Marylar	•	artment r <i>tificate</i>			nd Me	-	giene Reg. No	200	7	32039	3
77	Physicia	an	1. Decedent's Name (First, Middle	, Last)		Bokaı	<u> </u>				Date of De	Da	y Yea	ar	3. Time of Death	_
	/Medic	al	Sylvia 4a. Facility Name (If not institution	a give street and n	umhor)	DOKA	4b. City, To	own orlo	eation of I		eptem	1	17, 20 County of D		5:56 A.™	<u>M</u>
,	Examin	ier	3526 Greenly		umber)			lver					Montg		:y	
ī	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Under 1	Year If	f Under 24		Date of Bir (Month, Da	th v. Year)			ce (State or Foreign	7
	Director		116-09-2257	1□M 2 <b>X</b> □F		88 Yrs.	Months	Days	louis		April	3,	1919		inia	
	and w		Usual Residence of Decedent  10a. State 10b. County		10c. Cit	ty, Town or Lo	cation							10d	. Inside City Limits	_
	Maryl f sho ied at	ro	Maryland Mont	gomery	C	ilver :	Snring								1 ∏Yes 2 □ No	
	r 28a	irec	10e. Street and Number	30mer y	ن ا	TIACL	10f. Zip C			-		10g. Cit	izen of What	Country		_
	th wit 23a o 1st be	al D	3526 Greenly S	treet			2	0906				1	U. S	Α.		
	r dea tems er mu	Funeral Director	11. Marital Status	Armed F		l.S. 13.	Was Decede If Yes, specif	ent of Hispa fy Cuban, I	anic Origir Mexican, I	n? (Specif Puerto Ric	y Yes or No can, etc.)	-	14. Race - A Black, W			
20	rs afte	by F	1 ☐ Never Married 2 ☐ Marr 3 ☑ Widowed 4 ☐ Divorced	ied 1 ☐ Yes If Yes, G Year or	2 No Bive X Dates:		1 ☐ Yes 2l	XNo S	Specify:			ľ	Specify: W	hite	2	
3	2 hour atural cal Ex	ed k	15. Deceden	t's Education		16a. Dece	dent's Usual	Occupation	οn			16b. K	ind of Busine	ss/Indu	stry	
2	hin 7.	ple	(Specify only higher Elementary/Secondary (0-12)		(1-4or 5+)	(Give	kind of work DO NOT use	done duri retired)	ing most o	of working		Na	tional	Ins	stitute o	f
7	ed wit	Completed	12 Years			Gra	nt Spe							Hea	1th	_
2	be fill ntal H od oth even	Be	17. Father's Name (First, Middle,		_			18		•	First, Middle		Surname)			
Ž	hould d Mer marke maric	ပ္	Morris  19a. Informant's Name/Relations	Hollander	•	19b Mailir	na Address (	Street and			ldberg		or Town, Stat	e Zin C	ode)	
<u>2</u>	nd 2 s lith an 27 is i		Lynn B. Parker		er								ng, Md		,	
ກົ	of Hea item other	-	20a. Method of Disposition	_v	20b.	Place of Dispo cemetery, crei	sition (Name	e of ner place)	!	Date	e	20c. L	ocation - City	or Town	n, State	_
	Page nent c int: if iry or		1 ☐ Burial 2 🖺 Cremation 4 ☐ Donation 5 ☐ Other (S		n State	tional	-		9	/20/	2007	Fal.	ls Chu	rch,	Virginia	a
סמור	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatil and Mental Hygiene. Important: If tien 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service	Licensee	++++	2	banzan 1170 R	Address SKY-(					Chapel le, Ma			
8 6	16.2.		23a. Part1. Enter the disease, or shock, or heart failure. List	complications that	caused the ara									A	poroximate	-
	hysician		Immediate Cause (Final	only one cause on	Corona									1 5	nterval Between Onset and Death Years	
	/Medical		disease or condition resulting in death)	a. Due to	o (or as a consec			_						+		_
	Examiner		Sequentially list conditions.	b	Diabet		litus							20	) Years	
	ed sit	ine	Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events	Due to	o (or as a conse	uence of										
	execut n and al-trar	Examiner	that initiated events resulting in death) Last	c	o (or as a consec	quence of):										_
0/00	The law requires that the death certificate be executed ite has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	dical E		d												
0	tificat ng phy as the	fedi														_
200	tth cer tendir or use	Physician/Me	IF FEMALE: 23b. Was decedent pregnant		utcome pf pregn birth 2 DFeta		⊒Ectopic pre	gnancy				-	23d. Date of Month		ay Year	
5	ie dea the at hed fo	/sici	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Preg 9□Unk	gnant at time of a	death 5	Other (spe	cify)					MOTHE	U	ay rear	
·	that the		Part II. Other significant condition	ons contributing to	death but not res	sulting in the u	nderlying ca	use given i	in Part I.		23e. Did 1	lobacco	use contribut	e to the	cause of death?	_
ecords,	uires signe Id be	d by		-		_		-			1_	Yes 2	√2 No 3 □	Probab	oly 4 Unknown	,
5	w red s beer shou	Completed									24a. Was	an	24b. Were	autops	y findings available	
ב	The la te has age 2	dwo									auto perfe	psy ormed? X□ No	prior deati	1?	y findings available letion of cause of ☐ No	
	lan: rtifica stor, p	BeC	25. Was case referred to medica	1				20	6. Place o	of Death (6	1□ Yes Check only		,	C3 _		_
>	hysic his ce I direc	To E	examiner? 1∑XYes 2☐ No	Hospital: 1	Inpatient 2	] ER/Outpatier				ing Home	5 ☑ Resi	dence	6 □Other (S	Specify)		
5	Ing P		27. Manner of Death  M☐Natural 5 ☐ Pendin	ng (Mo	e of Injury onth, Day Year)	28b. Time o Injury		c. Injury at Work?			d. Describe	how inju	ry occurred			
2	ttend death. stor: / the f	icati	2 Accident investig 3 Suicide 6 Could	not be	ce of injury - At h	nome farm st	M factory		s 2□No	-	Location /	Stroot 2	nd Number o	- Rural F	Route Number,	
2	after after I Direct	Certification:	4 ☐ Homicide determ	ined buil	lding, etc. (Speci	ify)	eet, lactory,	onice		201	City or To	wn, Stati	e)	i iui ai i	iodie ivanibei,	
	To the Hospital or Attending Physician: The law requires that the death certifi within 24 hours after death.  Within 24 hours after death.  To the Funeral Director. After this certificate has been signed by the attending prompletely filled in by the funeral director, page 2 should be detached for use as		(Check only 2 Medical	ng Physician: To the Examiner: On the	basis of examin											_
	thin 2 thin 2 the I	Medical	one) 29b. Signature and title of certifie		anner state.		29c.	License n	umber			29d. Da	ate signed (M	onth. D	ıy, Year)	_
	1.1			- 6	10.	u	AI)		D095	77			-		3, 2007	
,	10		30. Name and address of person	who completed car		m 23a) (Type.	Print)		DU93	. , ,		56	r combe		,, 2007	_
			Dr. Richard H	enry Poll	Len 104	00 Con	nectio	ut Av	venue	#	606, I	Kens	ington	, Mo	1. 20895	
H	Sta Registr		31. Date filed (Month, Day, Year)	2007 32	egistrar's Sign	ature A	ant?									

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month 13, **JAKE** 2007 BELLO SEPTEMBER 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death 9707 OLD GEORGETOWN ROAD **BETHESDA** MONTGOMERY If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Months 1 X M 2 □ F 79 FEB 22, 556-48-4666 1928 MICHÍGAN Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1▼ Yes 2 No Director MARYLAND MONTGOMERY BETHESDA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9707 OLD GEORGETOWN ROAD 20814 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 📉 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: Specify: WHITE þ 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 5+ BIOCHEMIST CANCER RESEARCH 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be MAX BELLO ROSE GALANTER မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) EVA WETTEN/NIECE 1542 SUTAVA DRIVE, IVINS, UTAH 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 X Removal from State NATIONAL CREMATORIUM 9/26/2007 FALLS CHURCH, VIRGINIA 4 ☐ Donation 5 ☐ Other (Specify) 21 Signature | Fun and Howice Licensee 22. Name and Address of Facility DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC. 1170 ROCKVILLE PIKE, ROCKVILLE, 23a Part1. Enter the disease shock, or heart failure. e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 600 9 401 mZdisease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav 4□Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 24a. Was an autopsy perform 2 No 1□ Yes 25. Was case referred to medical 26. Place of Death Check onl one examiner? Other: 4 Nursing Home 1 Yes 2□ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 □Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury/ocqurred 28c. Injury at Work? ted gun shot 1 Natural 5 Pending investigation 1 ☐ Yes 2 No 2 Accident Sep 13 2007 3 Suicide 4 ☐ Homicide 6 Could not be determined 28e Place of injury - At home, farm, street, factory, office building, etc. (Specify) and Number or Rural Royte Number, Bether

Box 68760 P.0. **Physician** 

/Medical

Examiner

**Funeral** 

Director

t be notified at

or items 23a

72 hours after

Baltimore, Maryland 21215-0036

item 27 is marked other than "natural", or items 23a other traumatic event, the Medical Examiner must

d 2 should be filed with and Mental Hygier 7 is marked other the

permit. Pages 1 and 2
Department of Health a
Important: If Item 27 is
any Injury or other tran

**Physician** 

/Medical

Examiner

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Certification:

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29a, Certifier

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Signature and title of certifie

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certificate be executed Division or Vital Records, To the Hospital or Attending I within 24 hours after death.
To the Funeral Director; After

State Registrar

31. Date filed (Month, Day, Year 2 2007 SEP

mo omE egistrar's Signature

2 magel

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MO DME

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

December 1   December   Four Moths   Laber   September   22   2001   Laber   September   22   2001   Laber				For State Registrar		State of Ma	aryland		irtment of F <i>tificate of</i> :		nd Mei		giene.	2007	32041
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Physician Medical Examiner  Ph	, A	mark mark imatic	ř			ype, Print)		19b. Mailir	g Address (Street				er, City or	Town, State, Zip	o Code)
Physician Medical Examiner  Ph		alth a		Carmen Sa	lvaterra,	/Wife		225 R	idgeway A	Avenue	Cato	nsvill	le, N	D 21228	
Physician Medical Examiner  Ph	, .	of He of He if Item r othe				Removal from State	20b. Pla	nce of Dispo	sition (Name of natory or other pla	ce)	Date	9	20c. Lo	cation - City or To	own, State
Physician Medical Examiner  Ph		tment tent: I tent: I jury o		° 4 □Donation	5 Other (Specify	)	St.								
Physician //Medical Examiner  Physic		Departimbor		21. Signature of Fu	neral Service Licen	see with	M0104	4 4	. Name and Addre	ss of Facility Columb	Harry ia Pi	H. Wi ke Ell	itzke Licot	e's Fami	ly FH Inc. MD 21043
Sequentially ist conditions.   Sequentially ist conditions   Due to (or as a consequence of):		/Medical		shock, or hear Immediate Cause ( disease or condition	rt failure. List only ( Final	a	eta	sta		_		-		.er	Interval Between
FFEMALE:   23b. Was decedent pregnant in the past 12 months?   1   1   1   1   1   1   1   1   1		hysician and the burial-transit	dical Examiner	if any, leading to im cause. Enter Under Cause (Disease or i that initiated events	nmediate orlying injury	c		,							
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24a. Was an autopsy performed?   1	inge that	signed b	þ	Part II. Other signif	icant conditions o	ontributing to death b	out not result	ting in the u	nderlying cause giv	ren in Part I.					
25. Was case referred to medical examiner?  1   Yes   2   Xes   Xe	The law se	te has bee age 2 shou	omplete									autop perfo	osy rmed?	prior to co death?	empletion of cause of
State   Stat		ortifica ctor, p	0	25. Was case refer	red to medical					26. Place	of Death (0				
27. Manner of Death 1 SNatural 2   Accident 3   Suicide 4   Homicide 4   Homicide 4   Homicide 4   Homicide 5   Pending investigation 6   Could not be determined  28e. Place of Injury   28b. Time of Injury   M   28c. Injury at Work? 1   Yes 2   No  28f. Location (Street and Number or Rural Route Number, City or Town, State)  28g. Date of Injury   28c. Injury at Work? 1   Yes 2   No  28f. Location (Street and Number or Rural Route Number, City or Town, State)  28g. Date of Injury   28c. Injury at Work? 1   Yes 2   No  28f. Location (Street and Number or Rural Route Number, City or Town, State)  29a. Certifier (Check only one)  29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and place, and due to the cause(s) and manner as stated. 29c. License number 29d. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  E. Lee  1065 Cit Tite Potyxent PRWY, Columbia M 21044  31. Date filed (Month, Day, Year)  32 Jegistrar's Signature	hvoic	this ce	ပို	1 ☐ Yes 2 🔀		1 🗆 Inpatie			I 3 DOA	4 🗆 NUI					fy)
29a. Certifier (Check only one)  29a. Certifier (Check only one)  29b. Signature amonthised and place, and due to the cause(s) and manner stated.  29b. Signature amonthise of certifier (Specify)  29c. License number  29c. License number  29d. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  29c. License Pkwy, Columbia Minimal Control of the cause (s) and manner as stated.  29c. License number  29d. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  29c. License number  29d. Date signed (Month, Day, Year)  31. Date filed (Month, Day, Year)  32. Medical Examiner: Signature		After Auner	lon:	1 Natural	5 Pending	(Month, Da	iry y Year)					d. Describe t	now injury	y occurred	
building, etc. (Specify)  29a. Certifier (Check only one)  29a. Certifier (Check only one)  29b. Signature and title of certifier  29b. Signature and title of certifier  29c. License number  29c. License number  29d. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  E. Lee, 1065 Cittle Park ent Pkwy, Columbia Month, Day, Year)  31. Date filed (Month, Day, Year)  32. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  E. Lee, 1065 Cittle Park ent Pkwy, Columbia Month, Day, Year)  31. Date filed (Month, Day, Year)  32. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29d. Date signed (Month, Day, Year)		death ctor: y the	ficat	3 Suicide	6 Could not be	28e. Place of Inj	ury - At hon	ne, farm, str		163 2					al Route Number,
29a. Certifier (Chock only one)  29a. Certifier (Chock only one)  29b. Signature amblittle of certifier  29c. License number  29c. License number  29d. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  E. Lee, 1065 Crittle Patrixent Pkwy, Columbia, MD 21044  State  31. Date filed (Month, Day, Year)  32. Medical Examiner: On the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29d. Date signed (Month, Day, Year)  Sept. 24, 2007		s after	Serti	4 Homicide	determined	building, et	ic. (Specify)					City or Tov	wn, State,	)	
29b. Signature amount of certifier  29c. License number  29d. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  8. Lee, 11065 Cittle Patrixent Pkwy, Columbia, MD 21044  State  31. Date filed (Month, Day, Year)  32. Magistrar's Signature	ej coop o	24 hours e Funere letely fille		(Check only		niner: On the basis of	f examination								
Sept. 24, 2007  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  E. Lee, 11065 Little Patuxent Pkwy, Columbia, MD 21044  State  31. Date filed (Month, Day, Year)  32. Pagistrar's Signature	T.	Within To th comp	Me	29b. Signature	title of certifier	1 N.P	0 - 11	ik	29c. Licens	e number	1		29d. Date	e signed (Month,	Day, Year)
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State 31. Date filed (Month, Day, Year) 32. Agistrar's Signature	ر ارک			S / P.E.	ess of person who	Completed cause of C	eath (Item )	zsaj (Type,	ent P	KINU	(	وادر	mbi	a MD	21044
Registrar SEP 2 4 2007 Status & Appell	A .			31. Date filed (Mon.	th, Day, Year)	32. Kegistr	rar's Signatu	Jre A	Sache)	1,00	1/			71.00	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year September 19, 2007 **Physician** 2:53 P M Mary Ellen Bedwell /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b City Town or Location of Death **Examiner** Ceci1 Union Hospital E1kton If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day Year) Hours Min. 4. April 10, 5. Social Security Number 6. Sex Birthplace (State or Foreign
Country) 7. Age (In yrs. last birthday **Funeral** Year) Months Days 1 □ M 2 X F 75 1932 Maryland 217-58-7921 Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 28a-f show 1 Yes 2 No Director Maryland Ceci1 Chesapeake City 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ral", or Items 23a or Examiner must be 21915 37 Buddy Blvd USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Race - American Indian Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Int: If Item 27 is marked other than "natural", or Ite 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: White Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Dishwasher Restaurant or other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Cornell D. Ebanks, Sr. Marie Lloyd 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James D. Bedwell 37 Buddy Blvd, Chesapeake City, MD 21915 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State Chesapeake City 1 Nurial 2 Cremation 3 Removal from State September 24, 2007 Bethel Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Maryland 21. Signature of Funeral Service License 22. Name and Address of Facility 318 George Street R. T. Foard Funeral Home Chesapeake City, MD 21915 uchaso 23a. Part1 Enter the dise se, or complication that caus did the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cruce on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month 4□Pregnant at time of death 5 ☐ Other (specify) signed by the at the detached for 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 | Yes 2 | No 3 | Probably 4 | Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy perform 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Umpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Hatural

Division or Vital Records, P.O. Box 68760, Hospital or Attending s after dec. \*al Director; After

Certification: To 5 ☐ Pending investigation 1 ☐ Yes 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 🗲 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature d title of certifier 30.[Name and address of person who completed cause of death (Item 23a) (Type, Print) DIMONS 31. Date filed (Month Day) State Registrar

DHMH 17 Rev 1/2001

State Registrar 200

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

07-07595 Tanay L Blue Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

inay L Blue	1- For State	nd / Department of H <i>Certificate of D</i>				7 3204
Physician/	Registrar  1. Decedent's Name (First, Middle,Last)			Reg. 2. Date of Death		3. Time of Death
ledical Examine	TANAY L.  4a. Facility Name (if not institution, give street and nu	BLUE	City, Town, or Location of Death	Month D September 2	7, 2007	1129 hrs
	Prince George's Hospital Center		Cheverly		Prince George	's
Funeral	5. Social Security Number 6. Sex		f Under 1 Year If Under 24Hrs		MM/DD/YYYY) 9. Birt Foreigi	
Director	unk. 1_M 2_xF	Yrs.	Months Days Hours Min.	08/28		intry) Md
any	Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Location				10d. Inside City Limits
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the Maryland a or 28a-f show tiffed at once. Director	10e. Street and Number		Df. Zip Code	10g.	Citizen of What Coun	try?
~ ~ : -	7717 Garrison Road		20784		U.S.A.	
r death with the Maryland or items 23a or 28a-f she must be notified at once	1 X Never Married 2 Married Armed Fo		ecedent of Hispanic Origin? (Sp specify Cuban, Mexican, Puerto		14. Race - Americ White, etc.	can Indian, Black,
ral", or	3 Widowed 4 Divorced If Yes, Give Yea or Dates:		es 2 X No specify:		Specify:Blac	k
hours 'natura Ex mi	15. Decedent's Education (Specify only highest grad	during most	Usual Occupation (Give kind of vortion of working life. DO NOT use reti		6b. Kind of Business/li	ndustry
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5-00 led wir Hygien other the M	17. Father's Name (First, Middle, Last)		18.Mother's Name	(First, Middle, Mai	den Surname)	
121 Id be fi Aental I narked event,	Tony Hill  19a. Informant's Name/Relationship (Type, Print)	19h Mailing A	Stacey  ddress (Street and Number or F	B1ue		Zin Codo)
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after dea Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or it injury or other traumatic event, the Medical Examiner must not the Medical Examiner must not be a completed by Fur	Stacey Blue, Mothe	l l	Garrison Road		•	
re, rand Thealt filtern er trau	20a. Method of Disposition  1 X Burial 2 Cremation 3 Removal from	20b. Place of Dispositio	n (Name of cemetery,		0c. Location - City or	
Pages Pages ment of laint: I	4 Donation 5 Other Specify:	Harmony M	em Park 10		Landover	
Balt Sermit. Separti Import ujury	21. Signature of Funeral Service Licensee		e and Address of Facility HA			
Physician	23a. Part I. Enter the disease, or complications that co	021	Florida Ave			Approximate Interval
/Medical xaminer	failure. List only one cause of each line.  Immediate Cause (Final disease a. Suddan :	infant death syndro	1 <del>e</del>			Between Onset and Death
tailillei		consequence of):				
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ted Insit  Examiner	cause. Enter Underlyin Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a	consequence of):				
ecuted and - transit	d.			_		
60, ate be executhysician and the burial - tr.	Xunpended AMENDED #23a.2	7 perME_g874_ 12/19	/07 TT			
6876 certificate ading phy se as the b	23b. Was decedent pregnant in the	butcome of pregnancy			23d. Date of delivery Month	day Year
Box 68760, e death certificate be executed the attending physician and ed for use as the burial - transi hvstcian/Medical E.	1 Voc 2 M No 0   Unknown		(Specify)			
- e t e E	9 Ulikilo	o death but not resulting in the und	erlying cause given in Part I.	23e. Did toba	cco use contribute to	the cause of death?
ires that the signed by be detacled by F. O.				1 Yes	2 V No 3 Prob	ably 4 Unknown
of Vital Records, ug Physician: The law requires the this certificate has been signeral director, page 2 should be not To Be Completed				24a. Was an autopsy	prior to c	topsy findings available ompletion of cause of
tal Reco cian: The law certificate has ector, page 2 si				performe 1 <b>Y</b> Yes 2		s 2 No
ital lician: s certifi rector,	25. Was case referred to medical examiner?	EDIOMETER 1	26.Place of Death (Check			
on of Vital I ending Physician: ath. ir: After this certifi the funeral director, tion: To Be (	1 V Yes 2 No  27. Manner of Death  (Month	npatient 2 ER/Outpatient 3 of Injury 28b. Time of Injur		28d. Describe how	v injury occurred	:
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Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	one) 2 Medical Examiner: On the basis of	t of my knowledge, death occurred of examination and/or investigation				
A S S S S S	29b. Signature and title of certifier		29c. License number	2	9d. Date signed (Mo	nth, Day, Year)
	Doma nu manti	IMID.	O.C.M.E.		September 29, 2	007
R	30. Name and address of person who completed caused Donna M. Vincenti, MD Assistant M		enn Street, Baltimore, M	ID 21201		
State		gistrar's Signatule				
Registra	nct 1 2 200/ Marken	D. Oper				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMFND TTFM/26, perPHYS C872, 10/5/07 WS State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** Sauro Busan 7:55 AM September29,2007 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Pasadena Anne Arundel 505 Oak Road If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5 Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1X M 2□ F Months Days Hours Min Director 188-28-2645 October 10, 1935 Italy Usual Residence of Decedent Maryland 10d. Inside City Limits 10a State 10h County 10c. City, Town or Location an "natural", or items 23a or 28a-f show Medical Examiner must be notified at 1 ☐ Yes 2 ☐XNo Director Baltimore Baltimore Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code death with 21227 2904 Pennsylvania Avenue U.S.A. Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. Pages 1 and 2 should be filed within 72 hours after of ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural"; or iter ury or other traumatic event, the Medical Examiner 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify Specify.White Completed by 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) BG&E:Transpontation Supervisor: Body Shop 10 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Giovanni Busan Stephania 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 505 Oak Road Pasadena, Maryland 21122 Richard Busan/ Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of important: If it any Injury or o once. 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Bayview Crematory 10-2-07 4 □ Donation 5 □ Other (Specify) Baltimore, Maryland 22. Name and Address of Facility Marzullo Funeral Chapel, P.A 21. Signature of Funeral Service Licensee 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each tipe. 6009 Harford Road, Baltimore, Maryland21214 Approximate Interval Between Onset and Death Immediate Cause (Final 1 Cerpurata Physician ZUC disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical as the IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tohacco use contribute to the cause of death? Completed by 2**Q**No 1 🔲 Yes 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy perform this certificate or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 No Other:
4 \( \text{Nursing Home} \)

Other:

4 \( \text{Nursing Home} \)

Other:

6 \( \text{X} \)

Other (Specify) \( \text{Residence} \) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? After 1 Natural
2 Accident 5 Pending investigation To the mospher within 24 hours after death.

To the Funeral Director: At 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) the 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) 21438 2007

Registrar

 $Q_{j}$ 

State

30. Name and address of person who

MICHME

31. Date filed (Month

DEFOUSE HEHUM ANNAPOUS MID 2140

mpleted cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

EN

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Day Year Pauline M. Cover September 19, 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Wilson Health Care Center Gaithersburg Montgomery 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 M 2 XF 179-24-9840 Director 76 May 14, 1931 Pennsylvania Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Virginia Prince William notified Haymarket 1 ☐ Yes 2 ☑ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7 is marked other than "natural", or items 23a or traumatic event, the Medical Examiner must be r 15761 Hunton Lane 20169 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. ģ Specify: White 3 ☑ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry National Institutes (Give kind of work done during most of working life. DO NOT use retired) should be filed within ind Mental Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) of Health Chemist 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Paul Yarrish Catherine Butry and I 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2.
Department of Health at
Important: If Item 27 is
any injury or other train James R. Cover, Son 15761 Hunton Lane, Haymarket, Virginia 20169 Place of Disposition (Name of cemetery crematory or other place) 20a. Method of Disposition Sept. 26, 20c. Location - City or Town, State Gate of Heaven Mausoleum 1 ☐ Burial 2 ☐ Cremation 3 □ 📭 movel from State Silver Spring, MD 4 Donation 5 Nother (Specify) Intombiner 2007 22. Name and Address of Facility DeVol Funeral Home, 10 East 21. Signature of Funeral Service Li Deer Park Drive, Gaithersburg, MD 20877 23a. Pa x1. En ar he i ea s ock, or he art all ure Immediate Carse Fina disease or ondition resulting in death) Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death **Physician** /Medical Examiner Sequentially list conditions Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last the burial-tran Due to (or as a consequence of): physician Box 68760 Physician/Medical as attending nse IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 pronths?

1 \( \text{Yes} \) 2 \( \text{Y No} \) 23d. Date of delivery 3 ☐ Ectopic pregnancy for Month 4☐Pregnant at time of death 9☐Unknown Day 5 Other (specify) P.O. the detached 9 Unknown signed by 1 d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Division or Vital Records. þ 1 ☐ Yes 2 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has page 2 certificate 2 No I∏ Yes 25. Was case referred to medical examiner? Physician: Be of Death (Check only one) 26. Place Hospital: 1 ☐ Yes 2 No Other: 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3□ DOA 4 Nursing Home this 5 ☐ Residence 6 ☐ Other (Specify) funeral 27. Manner of Death 28a, Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred ospital or Attending I hours after death. After Certification: 5 Pending investigation (Month, Day Year) 1 ☐ Yes 2 ☐ No the Funeral Director: 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) within 24 To the I and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 004115 Sex tember 19,2007 211 30. Name and address of person who completed cause of death/(Item 23a) Type, Print Y, 208221 8/RSCHBACH NLD 201 RUSSELL AVENUE GALTHURSBURG, MD20841 31. Date filed (Month, Day, Year) gistr 32 ar's Signature State 21 2007 SEP Registrar

1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Enrique J. Carreras 19, 2007 7:53 A<sup>M</sup> September /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 01ney Montgomery Montgomery General Hospital If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number . Age (In yrs. last birthday 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 XM 2 ☐ F Director Sept. 11, 1925 Cuba 82 264-76-7391 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show r 28a-f show notified at 1 ☐ Yes 2 No Director MD Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? an "natural", or Items 23a or Medical Examiner must be 2601 Briggs Chaney Road 20905 Cuba Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 Yes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No Maryland 21215-0036 Specify: White 1 X Yes 2 ☐ No Specify: \$ 3 Widowed 4 Divorced Cuban Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) filed within Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) the d 2 should be filed w h and Mental Hygier 7 is marked other th Factory Worker <u>Factory Worker</u> other traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked i any InJury or other traumatle ev Candelaria Esther De La Vega Pedro Carreras ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) J. Carlos Manduley/Nephew 8503 Wild Olive Drive Potomac, MD 20854 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 09/22/07 Beltsville, MD 21. Signatore of Funeral Service Lic 22. Name and Address of Facility Going Home Cremation Service P.O. Box 784 MO1251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Acuk Physician Carchopulmany Arrest disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner be executed burial-transit and Due to (or as a consequence of): Box 68760 physician Physician/Medical the as attending IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No for Day Year Month 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a Ö 9 Unknown ٦. signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? or Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an cate has I autopsy performed? certificate 2 🔲 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မှ ŧ this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Division Certification: Hospital or Attending 5 ☐ Pending investigation 1 Natural the Funeral Director: At the Funeral Director: At the funeral Director At the 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) the 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 攻 18701 Prones Philp Olmy und 20832 MI Registrar's Signature 31. Date filed (Month, Day, State **SEP 24** Registrar

**Funeral** Director

	For			State	of Mary						lental F	, ,	-	^ ==		
_	1 - State Registrar						Certific	ate of	Death				<u>.20</u>	0/	320	
1	1. Decedent's Nar	ne (First, Midd	lle, Last)	)							<ol><li>Date of Month</li></ol>	Da	ay	Year	3. Time of De	
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	5. Social Security 118–26–1	829	6. Sex	x ]M 2 <b>⊠</b> F		n yrs. last birt	Yrs. Mon		Hours	Min.	8. Date of (Month, Mar.	Day, Year	1933	Cour	place (State or Fo otry) orida	
ŀ	Usual Residence of	10b. Count			10	c. City, Town	or Location							1	0d. Inside City L	
5	MD		•	ındel			rna Pa	-							1 ☐ Yes 2	
	10e. Street and No						10f	. Zip Code	211	4.0	****	10g. C	itizen of W	hat Cour	ntry?	
	327 Pres	SMTCK M				dent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-										
Dy ru	11. Marital Status 1 □ Never Mai 3 □ Widowed		rried	Armed F	orces? 2 X No ive	in U.S. 13. Was Decedent of If Yes, specify Ct		100	lispanic Or an, Mexica Specify:		cify Yes or No- Rican, etc.)		14. Race - American India Black, White, etc. Specify: White		etc.	
To Be Completed	(000	15. Decede	nt's Edu	cation	16a. Decedent's Usual Occupation 16b. Kir (Give kind of work done during most of working					Kind of Bu	siness/Ind	dustry				
	Elementary/Sec	ondary (0-12)	est grade		) (1-4or 5+)	(Give kind of work done during most of working life. DO NOT use retired)  Homemaker							_	nd of Business/Industry		
	12	, , ,			,	Homemaker Home										
	17. Father's Name Robert		, Last)			18. Mother's Name (First, Middle, Maiden Surname)  Lillian Dillon										
	19a. Informant's Name/Relationship (Type. Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State,										State, Zip	Code)				
	Robert E. Clarke/Husband 327 Preswick Way Severna Park, MD 21146												46			
Î	20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)  20c. Location - City or Town, S												own, State			
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ŀ	21. Signature of F				L		22. Nam	e and Addre	ss of Facili	ity _	2007					
	1	Q (		din			Barr	canco -	& Son	ış, P	.A. Ş	ever	na Ra	irk F	uneral MD 2114	
Examiner	23a. P Enter shock, or he Immediate Cause disease or condition	(Final on	or compli t only or			e death. Do n	not enter the		ng, such as				na Pa	irk,	Approximate Interval Between	
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	Funeral
	Director
ryland 21215-0036	hould be filed within 72 hours after death with the Maryland d Mental Hygiene.  marked other than "natural", or Items 23a or 28a-f show matic event, the Medical Examiner must be notified at

Physician /Medical Examiner

3altimore, Ma

The law requires that the death certificate be executed attending physician and for use as the burial-tran signed by the a

Division or Vital Records, P.O. Box 68760,

State of Maryland / Department of Health and Mental Hygiene 2 0 0 7 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 21 3. Time of Death Month **Physician** 6:00 A M Virginia Edith September 2007 Craw /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Solomons Nursing Center Solomons Calvert if Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Nov. 24 1918 5. Social Security Number 7. Age (In yrs. last birthday 9. Birthplace (State or Foreign Days 1 □ M 2 🔀 F Months Hours 568-38-7536 88 Michigan Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 XNo Directo MD Calvert Prince Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 249 Double Oak Road, North 20678 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1∆ Yes 2 □ No WWII If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: <u>Ş</u> Specify: white 3 Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) registered nurse health care 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Harold Houldsworth Eva Virenda Weaver 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20678 permit. Pages 1 and 2 sho Department of Health and I Important: If Item 27 Is ma any injury or other trauma 19a. Informant's Name/Relationship (Type. Print) Julie Wizorek, daughter 249 Double Oak Road, No., Prince Frederick, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Metropolitan Crematory 9/21/2007 Alexandria, VA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Rausch Funeral Home, P.A. PO Box 600, Lusby, MD 20657 23a. Part1. Enter the "isease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Cardio Vascular disease therosci disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Heart Congestive 1 Yes 2 No 3 Probably 4 12 Onknown Completed Atrial 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an Hypothyroidism 1∐ Yes 2 1 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ASST UVING 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Natural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 THomicide 24 hours e Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D 50653 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ayan-c 2RN\_3+1 5851church eale Road 31. Date filed (Month, Day, Year) 32. Registra Signature State SEP 2007▶ Registrar

State of Maryland / Department of Health and Mental Hygien [ ] [ ] 32050 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 8:30 am September Helen Foley Dorman 16 2007 /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Brooke Grove Nursing Home Sandy Spring Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 ☐ M 2 🖾 F February 10,1915 District of Columbia 92 Yrs Director 212-68-0879 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ehow the Medical Examiner must be notified a 1 Yes 2 No Maryland Montgomery Sandy Spring Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö or Items 23a 18201 Slade School Road 20860 U.S.A. Funeral death 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify þ 3 XWidowed 4 ☐ Divorced White 'natural' Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 should be fi and Mental F is marked of permit. Peges 1 and 2 should be Department of Heelth and Mental Importent: If Item 27 is marked any injury or other traumatic evenance. Walter R. Foley Josephine Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15211 Elkridge Way, #1A, Silver Spring, Maryland 20906 Caroline Royston - Friend 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln Crematory 10/01/2007 Brentwood, Maryland 21. Signature of Funeral S in ice Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 Torus Approximate Interval Between Onset and Death 23a. Part 1. En er the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, heart failure. List only one cause on each line. neumonia Immocian Cause (Final disease or condition resulting in death) Physician 2 hours /Medical hronic Obstructive la luciny De Recse Examiner 20 selec Sequentially list conditions, if any, loading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) physician a s tha burial-P.O. Box 68760 Physician/Medical IF FEMALE: If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown igned l Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 3 ☐ Probably 4 ☑ Únknown 1 ☐ Yes 2 ☐ No Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? paga 2 autopsy performed? 1 ☐ Yes 2 🗹 No certificete 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ဥ 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation filled in by the f 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) To the Hospins.
within 24 hours effer of
To the Funerel Directompletely filled in br 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 131918 September 16, 2007 W.O-terus mo 20 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WARREN O- FERRIS MED, 3305 NORTH LECSULY World Goellevand, SIVEN Sevicy Maryland 20906 31. Date filed (Month, Day, Year) SEP 2 1 2007 State

Registrar

			1- For Amend Item 18 State Registrar WCHD/SH 9/	State of Mary 28/07 per FF	rland / Depa	artment of F		lental Hyg	iene .g. <b>\2</b> 0 (	7	320	51
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	Examir		4a. Facility Name (If not institution, gir	ve street and number)		4b. City, Town, o	r Location of Death	•	4c. County	of Death		
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5-0036	is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene item 27 is marked other then "neturel", or items 23s or 28e-1 show other treumatic event. The Medical Exercise for its profitted at	þ	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	į	If Yes, specify Cuba 1 ☐ Yes 2X No	lispanic Origin? (Spi an, Mexican, Puerto Specify:	Rican, etc.)		ck, White,		
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7	2 should be faund Mental His marked of eumatic ever	2	William Jenkins  19a. Informant's Name/Relationship	(Type Print)	10h Mailie	ng Address (Street	Alice	Delaude	£			
	and 2 s saith an n 27 is ier treu		Edward Sweet - So				er Avenue					17/0
Baltimore,	9 = 5		20a. Method of Disposition  1  Burial 2  Cremation 3  4  Donation 5  Other (Speci	Removal from State	20b. Place of Dispo cemetery, crer	sition (Name of matory or other plac	· · · · · · · · · · · · · · · · · · ·	Date	20c. Location	City or To	wn, State	
altin	구두분분		21. Signature of Funeral Service Lice		114 22	2. Name and Addres	ss of Facility Mi	nnich F	uneral	Home	матута	ina
m	Departing Important in any in		Fred L. B	estal			son Blvd.				and 217	740
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of Vital Records, P.	juires that I n signed by ild be deta	by	Part II. Other significant conditions	contributing to death but no	ot resulting in the u	nderlying cause give	en in Part I.		eacco use cont			
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of	Phys this ral dir	٠ <u>۲</u>	1 ☐ Yes 2 ❤️No 27. Manner of Death	Hospital: 1 ☐ Inpatient  28a. Date of Injury	2 ER/Outpatien		404 Hursing Flor	me 5 Reside 28d. Describe ho			)	
OU	Attending I r death. ector: After by the funer	tion	1 Matural 5 ☐ Pending 2 ☐ Accident investigatio	(Month, Day Ye	ar) Injury	Work	(? Yes 2 □ No	LOG. Describe No	w injury occur	160		
Division	I or Attendath after death Director: A	Certification:	3 Suicide 6 Could not be determined	O O Olaco of laiva	At home, farm, streepecify)	eet, factory, office	Ţ,	28f. Location (Str City or Town	reet and Numb , State)	er or Rurai	Route Number	er,
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	To the within 2 To the complet	Med	29b. Signature and title of certifier	and mariner stated.		29c. License	number	29	d. Date signe	d (Month, L	Day, Year)	
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			For State Registrar		State of	f Marylan	d / Dep <i>Ce</i>	artmen	t of H	lealth a Death	and M	lental Hy	giene Reg. No	200	7 33	2052
	Physic	an	1. Decedent's Name	, ,	,			Timoat		Joann		2. Date of Do	eath		3. Tir	ne of Death
	/Medi Exami	cal	Felix J 4a. Facility Name (If I					4b. City,	Town, or	Location	of Death	Septer		. County of		25 P.M
	A Secretary of the second		Asbury-So  5. Social Security Nu		s Health (				mons	If Under	24 Hrs	0 0-440		Calver		
1	Funeral Director		141-14-5	621	1 <b>X</b> M 2 □ F	7. Age (In yrs. i	Yrs.	Months		Hours	Min.	8. Date of Bi (Month, D 02–16-	-1920	N C	Birthplace (St Country) New Jers	ate or Foreign Sey
	yland how at			10b. County		1	, Town or L								10d. Insid	de City Limits
	the Mar 28a-f sl	Director	MD  10e. Street and Num	Calve	ct —————	So	10mons		0-4-				10 04	tizen of Wha		Yes 2 <b>X</b> No
	th with 23a or 1st be r	al Dii			ircle, Ap	t. #103		10f. Zip	0688				_		States	
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status 1 □ Never Marrie 3 □ Widowed 4		Armed For	2 🗆 No		Was Deced If Yes, spe 1 ☐ Yes		ispanic Or in, Mexica Specify:		ecity Yes or No Rican, etc.)	0-		American India White, etc. White	n,
15-0	n 72 ho "natur edical l	leted	(Specif	15. Decedent' fy only highes:	s Education t grade completed)		16a. Dece	edent's Usua e kind of wo DO NOT us	al Occupa	ation during mos	st of work	ing	16b. K	ind of Busir	ness/Industry	
212	ed withli /giene. er than t, the M	Be Completed	Elementary/Second		College (1	-4or 5+)		jineer			_		Arc	chitur	e Repre	esen <del>a</del> tiv
and	d be file ental Hy ked oth c event	To Be (	17. Father's Name (F		•							e (First, Middle a Perri		Surname)		
Baltimore, Maryland 21215-0036	2 should and Miles man	1	19a. Informant's Nan			Wife	4	_				al Route Numb				20699
re, l	s 1 and of Health item 27 other t		20a. Method of Dispo	osition	th DiFranc	20b. P	lace of Disperentery, cre					Apt. #1			nons, Mi ty or Town, Stat	
timo	t. Page rment c rant: If		4 □ Donation 5	5 ☐ Other (Sp		State	ropol	itan	Crem	atory		23/07	Ale	xandr	ia, Vir	ginia
Ba	permit Depar Impor any ir		21. Signature of Fun	neral Service L	icensee /			2. Name ar			1/0	ausch F by, Mar			me, P.A	١.
	والمحال			t tailure. List o	complications that cannot only one cause on ea	aused the death ach line.									Approx Interva	timate I Between and Death
	Physician /Medical		Immediate Cause (F disease or condition resulting in death)	·inal	a Due to (	or as a consequ	uence of):	wyo	ne	t						MINS
	Examiner	<u>.</u>	Sequentially list cond	ditions,	b	or as a consequ	ience of):									
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760,			resulting in death) La	ast	Due to (d	or as a consequ	uence of):									
89 >	ertificate ing phy e as the	Medic	IF FEMALE:		d											
Division or Vital Records, P.O. Box 6876	The law requires that the death certificate be tte has been signed by the attending physicis bage 2 should be detached for use as the bu	Physician/Medical	23b. Was decedent p in the past 12 m 1 ☐ Yes 2 ☐ 9 ☐ Unknown	nonths?		irth 2 ☐ Fetal ant at time of de	death 3[	⊒Ectopic pr ⊒ Other <i>(sp</i>						23d. Date o Month		Year
ords, F	w requires tha been signed I should be det	by	Part II. Other signific	cant condition	ns contributing to de	ath but not resu	llting in the u	inderlying c	ause give	en in Part I	•				ute to the cause	
tal Rec		Completed	25. Was case referre	and to provide a								1□ Yes	psy ormed? 2 100	prio dea	re autopsy findi or to completion uth? IYes 2 ☐ No	of cause of
r Z	Physicia this certi	To Be	examiner?				ER/Outpatie	nt 3 DC	Othe			me 5 Res	IIM U	6 Other	(Specify)	elite
ion	nding P th. : After t e funera		27. Manner of Death 1 ☐ Natural 2 ☐ Accident	5 ☐ Pending investiga	· ·	of Injury h, Day Year)	28b. Time o Injury	of 2	8c. Injury Work 1 □ \	/ at t? Yes 2 □		28d. Describe	how inju	ry occurred	0	/
Jivis	or Atter tfer dea Director in by the	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could no determin	and Zoe. Flace	of injury - At ho ng, etc. (Specify	me, farm, st	reet, factory	, office			28f. Location ( City or To	Street an wn, State	nd Number (	or Rural Route	Number,
	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certifica completely filled in by the funeral director, to	Medical Ce	29a. Certifier 1 (Check only 2 one)	1 ☐ Certifying 2☐ Medical E	Physician: To the examiner: On the ba	asis of examinat	wledge, deat	th occurred	at the tim	ne, date ar pinion, dea	nd place, ath occur	and due to the red at the time	cause(s	) and mann d place, and	er as stated. I due to the cau	use(s)
	To the within To the comple	Mec	29b. Signature and ti	itle of certifier	7 / 4	or stated.	0	290	. License	number	<i>+</i> 7 7	(-)	29d. Da	te signed (//	Month, Day, Ye	ar)
			30. Name and address	ss of person w	ho completed cause	e of death (Item	23a) (Type	Print)	1	9		( (	0	9/2	22/07	7
drw	10+1		BA	THE	2 MODES	pypo	/ 110		PITI	n f	COAD	#2	04,	Pr fr	ederic	£ 110
	Sta Registr	_	31. Date filed (Month	SEP	2 4 2007	Strewa	· K	Spe	W.						LCK	76

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0.07

			1 - For State Registrar	State of Mary	C	ertificate of L	eaith and M Death		g. No.	1	32053
	Physici	an	1. Decedent's Name (First, Middle, La					2. Date of Death Month	Day \	r'ear	3. Time of Death
Į.	/Media	cal	Michael Johr		s, Sr.	1		Septemb	er 27 20	007	1:00 A M
E.	Examir	er	4a. Facility Name (If not institution, gi		Jonton		Location of Death		4c. County of Anne		ada 1
	Funeral		Annapolis Nursir 5. Social Security Number 6.	Sex 7. Age (In	yrs. last birthda	Annapo (y) If Under 1 Year	II Under 24 Hrs.	8. Date of Birth (Month, Day,			ace (State or Foreign
	Director		578-20-9775	1⊠M 2□F	81 Yrs	Months Days	Hours Min.	Oct. 10			ington, DC
	and w		Usual Residence of Decedent  10a. State 10b. County	10	c. City, Town or	Location				10	d. Inside City Limits
	Maryl f sho	ļo	MD Calve			ingtown					1 ☐ Yes 2 🛣 No
	r 28a	rec	10e. Street and Number			10f. Zip Code		10	g. Citizen of Wh	nat Count	ry?
	th with	a D	4220 Jenna Court	_		20639	)		United	Sta	tes
	tema arma	Funeral Director	11. Marital Status	12. Was Decedent Ever Armed Forces?		3. Was Decedent of Hi If Yes, specify Cuba	spanic Origin? (Spe n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Black.	- America White, e	
30	be filed within 72 hours after death with the Maryland tal Hygiene. d other than "natural", or items 23s or 28s-f show event, if a Mudical Examinat must be notified at	by Fi	1 ☐ Never Married 2 ☐ Married  3 ☑ Widowed 4 ☐ Divorced	1X Yes 2 □ No If Yes, Give Year or Dates:	1944– 1947	1 ☐ Yes 2🌠 No	Specify:		Specify:		nite
215-0036	2 hou	ted	15. Decedent's E	ducation	16a. De	cedent's Usual Occupa	ition	1	6b. Kind of Busi		
7	thin 7	Completed	(Specify only highest gr Elementary/Secondary (0-12)	College (1-4or 5+)	life	ve kind of work done of a. DO NOT use retired,	uring most of worki )	ng			
2	filed w Hygier other th		47 Entrada Nova (Fina Middle )	4		Musiciar			enter		ment
yland	otal H	Be	17. Father's Name (First, Middle, Las. John	DeSantis			18. Mother's Name Elvera	) (First, Middle, M			
<u> </u>	should nd Me mark matic	ို	19a. Informant's Name/Relationship		19b. Ma	ailing Address (Street a		Il Route Number	Botta:		Code)
Mar	alth ar		Debra Malay, dau	•		1220 Jenna				2063	
g.	of He of He fitem	. 1	20a. Method of Disposition 1 ØBurial 2 ☐ Cremation 3 [	2	Ob. Place of Dis	position (Name of rematory or other place	g)   C	ate 2	0c. Location - C	ity or Tov	vn, State
Ĕ	Pag ment ant: fi		4 Donation 5 Other (Speci	Triginoval nom otale		Heaven Cen	n. 10-03	-2007	Silver	Sprin	ng, MD
Saltimor	permit. Pages 1 and 2 should be Depertment of Health and Menta Important: if Item 27 is marked any injury or other traumatic events.	0	21. Sprature of Funeral Service Lice	nsee		22. Name and Addres					
	40240		23a. Part1. Enter the disease, or con	polications that caused the	death Do not		. Harmony				20736 Approximate
	Discontinuo		shock, or heart failure. List only Immediate Cause (Final	one cause on each line.			•		-		Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a Due to (or as a co		obelavo	1100450	144 DI30	hal	L	114125
	Examiner			505 to (61 u3 u 00	risoquerice or).						
-	₽ =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a co	nsequence ol):						
1	and trans	kam	Cause (Disease or injury that initiated events resulting in death) Last	C. Due to for an a co	and unable of the						
00/00	rificate be executed og physicien and as the burial-transit	fedical Examiner		Due to (or as a co	nsequence or):						
200	difficate	edlc		_ d							
ŏ	h cert ending	In/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pr		DEstania erasanau			23d. Date	of deliver	у
מ	e death he atten ed for u	Physician/N	in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Pregnant at time		3 □Ectopic pregnancy 5 □ Other (specify)			Month	1 [	Day Year
7	hat the deby to detach		9 ☐ Unknown  Part II. Other significant conditions	-	at reculting in the	undarhina anuan mu	e in Bort I	220 Did tobo	ann una anatab	uto to the	cause of death?
as,	The law requires that the death cer site has been signed by the attendir page 2 should be detached for use	d by	Chroniz C		Zes To R		murani.				bly 4 Unknown
Š	w requir been si should	lete						24a. Was an	24h Wa	are auton	sy lindings available
ב נ	ding Physician: The lav h. After this certificete has funeral director, page 2	Completed						autopsy perform	ed? dea	or to com	pletion of cause of
	ian: rtifice ctor, p	BeC	25. Was case referred to medical			- No	26. Place of Death	1 ☐ Yes 2 Check only one	-	Yes 2	: _ No
5	Physician: this certifice ral director,	To	examiner? 1 Yes 2 No		2 ER/Outpat		4 Nursing Hor	ne 5 ☐ Residen	ice 6 □Other	(Specify)	
=	ling P	ü	27. Manner of Death 1 ☐ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Yea	ar) 28b. Time Injur	/ Work		28d. Describe how	v injury occurred	1	
<u> </u>	I or Attendi after death. Director: A I in by the fu	ficat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	9 Ope Olege of Injury	At home, farm		'es 2 □No	281. Location (Stre	eet and Number	or Rural	Route Number
2	al or after	Certification;	4 Homicide determined	building, etc. (S	pecify)	street, factory, office		City or Town,	State)	o, notari	House Namber,
	To the Hospital or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the funerel completely filled in by the funerel completely filled in by the funerel completely filled in the funerel c		29a Certifier Certifying Pl	ysician: To the best of my	knowledge, de	ath occurred at the tim	e, date and blace, a	and due to the car	se(s) and mann	ar as sta	lid.
	the H the F the F molete	Medical	one	miner: On the basis of exa and manner stated.	mination and/or						
	or we co	~	29b. Signature and title of certifier	110.00	)	29c. License		_	d. Date signed (		*
	_		30. Name and address of person who	completed cause of death	(Item 23a) (Tue	a Print)	7 .03	- 00	PIEM	BER	20 1007
	15		2	EVORE M	(A)	9. Print) 203 QU	eensb	Ung L	4 146	alt	Wille MA
	Sta		31. Date liled (Month, Day, Year)	2. Registrar's S	Signature	all s					20781
	Registr	ar	OCT 0 5 200	11 Kleston J	is post	60					-

IVISION OF VIIAI RECORDS, P.O. DOX 00/00,	Daltillore, Maryland 21213-0030
or Attending Physician: The law requires that the death certificate be executed	permit. Pages 1 and 2 should be filed within 72 hours after death w
ther death.  Need and After this certificate has been signed by the attending physician and	Department of Health and Mental Hygiene.  Important: If item 27 is marked other than "natural", or items 23a
in by the funeral director, page 2 should be detached for use as the burial-transit	any Injury or other traumatic event, the Medical Examiner must b
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		For State Registrar	State	OI Mai ylaili	u / Dep Ce	ertificate d	of Death	u Mentan	Reg. N	2007	32054	
		Decedent's Name (First, Middle	le, Last)					2. Date of Month	Death	ay Year	3. Time of Death	
Physicia Medic/		Louis	Joseph F	oehrkolb				Sept.	20,	2007	0430 M	
Examin		4a. Facility Name (If not institutio	n, give street and n	number)		,	n, or Location of D	eath	4	c. County of Dea		
		Carroll Host  5. Social Security Number	oital Cen 16.Sex	ter 7. Age (In yrs. Is	ast hirthda		unster ear   If Under 24	Hrs. 8. Date of	Birth	Carro	Thplace (State or Foreign	
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ow	ŀ	Usual Residence of Decedent  10a. State 10b. County	/	10c. City	, Town or	Location					10d. Inside City Limits	
ied a	to	Maryland Cari	m11		West	minster					1 ∐Yes 2 <mark>1</mark> 2 No	
or 28a	Director	10e. Street and Number	.011			10f. Zip Cod	de		10g. C	itizen of What C	Country?	
23a c ust be	la	4001 Turkeyfo	ot Rd.				21158			USA		
ter m	Funeral	11. Marital Status	Armed	ecedent Ever in U.: Forces?	S. 13	<ol> <li>Was Decedent If Yes, specify</li> </ol>	of Hispanic Origin Cuban, Mexican, P	? (Specify Yes or uerto Rican, etc.)	No-	14. Race - Am Black, Wh		
l", or i xamîn	by F	1 ☐ Never Married 2 ☐ Mar 3 ☐ Widowed 4 ☐ Divorced	If Yes. (	s 2 <b>X</b> No Give Dates:		1⊡Yes 2√2	No Specify:			Specify:	White	
atura cal E		15. Deceder	nt's Education		16a. Dec	edent's Usual O	ccupation		16b.	Kind of Busines		
an "n Medi	Completed	(Specify only higher Elementary/Secondary (0-12)	est grade complete College	(1-4or 5+)	Sa	1esman	one during most of tired)	working	Wh	olesale	Seafood	
t, the	Con	12					40 84-45	Name /Fine Adid	ula Adaida	(		
ed oth	Be	17. Father's Name (First, Middle Joseph Foeh)					Ida E	Name (First, Mid	uie, iviaiue	en Sumame)		
mark	ဥ	19a. Informant's Name/Relation			19b. Ma	iling Address (St	reet and Number of		mber, City	or Town, State,	, Zip Code)	
27 is r trau		Barbara Foehrko		rife		Turkeyf			-	er, MD		
item othe		20a. Method of Disposition		20b. P	lace of Dis	position (Name of rematory or other	f i	Date		Location - City of		
ant: If ury or		1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (		Car:			on Inc 9/				, Maryland	
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signeture of Funeral Service	Licensee			22. Name and A	ddress of Facility P nington R	ritts Fu	nera.	1 Home a	& Chapel, PA 21157	
0.47		23a. ht1. Enter the diseas shock, or heart failure. Lis	complications that	at caused the death	n. Do not e	enter the mode of	dying, such as ca	rdiac or respirator	y arrest,	er, 1410	Approximate Interval Between	
sician		Immediate Cause (Final disease or condition		ERTENS	NE	AND	ATHER	OSCLE	ROT	TC	Onset and Death	
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To the Funeral Director: After this certificate has been signed by the attendin completely filled in by the funeral director, page 2 should be detached for use	Medical Co	29a. Certifier 1 Certify (Check only one) 2 Medica	ring Physician: To al Examiner: On the and m	the best of my kno e basis of examina nanner stated.	owledge, de ation and/or	eath occurred at to investigation, in	he time, date and my opinion, death	place, and due to occurred at the ti	the cause me, date a	e(s) and manner and place, and d	as stated. lue to the cause(s)	
Fo the	Me	29b. Signature and title of certification		_ /		29c. Li	cense number		29d. [	Date signed (Mo	onth, Day, Year)	
5		I VA	2	>gr/h	2	J C	4345	3	0	9/20	12007	
3		30. Name and address of perso	NG.M.1	200	ME	e, Print) MORIA	L AVEN	SWE	WES	STMIN:	STER MD	
Sta		31. Date filed (Month, Day, Yea		2. Registrar's Signa	ature	•						
Regist	ar	SEP 2	2 1 2007	KIRWA	15	break ,						

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** September 19, 2007 2:25 A<sup>M</sup> Rose B. Gross /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery 6111 Montrose Road, #403 Rockville 8. Date of Birth (Month, Day, Year) November 7, 1910 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1 □ M 2 🖺 F Yrs. Director 159-34-7293 96 Massachusetts Usual Residence of Decedent the Maryland 10c. City. Town or Location 10a. State 10d. Inside City Limits 10b. County show at r 28a-f shi 1 X Yes 2 □ No Director Rockville Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with 1 ment of Health and Mental Hygiene. 5 g ns 23a must b 20852 ILS.A. 6111 Montrose Road, #403 by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify Specify. 3 ⊠ Widowed 4 □ Divorced White 'natural', er than "natur, the Medical E Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Librarian Library 7 Is marked othe traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be David Baker ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 I Irwin Gross - Son 6602 Hillandale Road, Chevy Chase, Maryland 20815 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition Date 20c. Location - City or Town, State Department of F Important: If ite any injury or other 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Har Jehuda Cemetery 9/23/2007 Upper Darby, Pennsylvania 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. (Ila 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician Conga + i se Due to (or a consequence of): disease or condition resulting in death) /Medical Examiner Sequentially list conditions, Due to (or as a consequence of) Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed attending physician مناطرة عليه عندا عليه عنداً عليه عنداً المناط Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☒ No
9 ☐ Unknown 23d. Date of delivery 3 Ectopic pregnancy Dav Year signed by the at d be detached for 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown Spinal Stenosis 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an Depression certificate has t rector, page 2 s autopsy performed Osteoperosis 1 Yes 2 No or Attending Physician: 25. Was case referred to medical examiner? director, Medical Certification: To Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 🖾 Residence 6 Other (Specify) 1 Yes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 28a. Date of Injury 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 ☐ Pending investigation Injury (Month, Day Year, 1 Natural within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Hospital 1 🖸 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one To the 29c. License number 29d. Date signed (Month, Day, Year) 29h. Signature and title of certifier 107 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Zeba Shaheen Geloo, M.D., Hirsh Health Center, 1801 E. Jefferson Street, Rockville, Maryland 20852 31. Date filed (Month, Day, Year) SEP 2 1 2007 32. ₽gistrar's Signature State Time Registrar

			For State	State of	Marylan		artment of H		Mental Hy		007	22056
71.			Registrar  1. Decedent's Name (First, Middle, I	l aet)		Cel	rtificate of L	Jeath	2. Date of D	Reg. No	007	32056
	hysici		Philomene	,		Geri	nain		Month	Day	Year 2007	10 S3 A M
	/Medic		4a. Facility Name (If not institution,		iber)	00,7	4b. City, Town, or	Location of Dea	-	4c. C	ounty of Death	10-271
			Laurel Region	nal Hos	pital		Lau	rel		Pri	nce G	orge
	neral			. Sex 1 ☐ M 2 🔯 F	7. Age (In yrs.		If Under 1 Year Months Days	If Under 24 Hrs Hours Min	. (Month, D	rth ay, Year)		lace (State or Foreign
	ector		218-31-1345 Usual Residence of Decedent		66	113.			July 16	, 1941		Haiti
yland	at ow		10a. State 10b. County		10c. City	y, Town or Lo	cation				1	0d. Inside City Limits
e Mai	tified	Director	Maryland Prince	George's			I	Laurel				1 ☐ Yes 2 ☑ No
vith th	be no		10e. Street and Number				10f. Zip Code			10g. Citize	n of What Cour	itry?
eath v	must	Funeral	14802 Be1 Am	i Drive	dent Ever in II	S 13 V	Was Decedent of Hi	20707	Specify Ves or N	0. 114	Haiti . Race - Americ	an Indian
offer d	niner		1 ☐ Never Married 2 ☑ Married	Armed Ford	ces? 2⋉No	1	f Yes, specify Cuba	n, Mexican, Pue	rto Rican, etc.)	0.	Black, White,	
ours a	Exan	d by	3 Widowed 4 Divorced	If Yes, Give Year or Da	e tes:		1 ☐ Yes 2₺ No	Specify:		S	pecify:	Black
72 h	dical	Completed	15. Decedent's (Specify only highest of	Education grade completed)		(Give	dent's Usual Occupa kind of work done d	uring most of wo	orking	16b. Kind	of Business/Inc	dustry
withir ene.	he Me	dmc	Elementary/Secondary (0-12) 12	College (1-	4or 5+)	ille. I	00 NOT use retired, Homemak				Priva	ite
should be filed within 72 hours after death with the Maryland ind Mental Hyglene.	rent, f	BeC	17. Father's Name (First, Middle, La	est)				18. Mother's Na	me (First, Middle	, Maiden Si	urname)	
wild be Menta	atic e	To E	Therageune D	ay				E	Elina Rene			
2 sho	raum		19a. Informant's Name/Relationship	(Type. Print)			ng Address (Street a					Code)
1 and 2 Health	thert		Jean C. Germain -	Husband	20h P		Bel Ami Dr	rive, Laur	rel, Maryl		107 Ition - City or To	State
Pages nent of	yoro		1 ☑ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe		State	emetery, crer	natory or other place	' i .	4/2007		,	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mertal Hygiene.	i i i		21. Signature of uneral Service Pic		Gal	22	aven Cemete  Name and Addres	s of Facility			r spring,	Maryland
De de	any ir	. 1	* Kalph &	Wille	un		Lnes <b>-</b> Rinaldi L800 New Ham				ing, Mary	land 20904
			23a. Part1. Enter the disease, or co shock, or heart failure. List or	ily one cause on ea	ich line.					arrest,		Approximate Interval Between
Physi			Immediate Cause (Final disease or condition resulting in death)	_a. Avi	OXIC	Bro	in my	ung				Onset and Death
/Med	dical niner		resulting in death)	Due to (c	or as a consequ	uence of):	in Inj	11	1.4			
		er	Sequentially list conditions, if any, leading to immediate	b. Due to (c	or as a consequ	uence of):	= C1 100 V	145016	1201			ment45
cuted	ransit	Examiner	Securitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	G.								
6 exe	urial-tı		resulting in death) Last	Due to (o	or as a consequ	uence of):						
cate be executed	the burial-transit	dical		d								
To the Hospital or Attending Physician: The law requires that the death certificate hours after death.  To the Funeral Director. After this certificate has been stoned by the attending.	should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outc						23	d. Date of delive	20/
death	d for t	iciar	in the past 12 months?	4□Pregna	ant at time of de		]Ectopic pregnancy ] Other (specify)			23	Month	Day Year
at the	tache	hys	9 □ Unknown	9□Unknov								
res th	be de	ρ	Part II. Other significant conditions  (alletes Me		4.1	Ilting in the ur	, ,	n in Part I.				ne cause of death?
r requir	plnould	eted		( /	/ / /	1021	210-7		-			ably 4 donknown
ne faw	ge 2 s	Completed	Chronic re	ma	COI IUI	e	·		24a. Was		24b. Were auto prior to cor death?	psy findings available inpletion of cause of
an: T	or, pa		25. Was case referred to medical					26 Place of De	1□ Yes	2 1 No	1 ☐ Yes	2□ No
ysicia is cert	direct	o Be	examiner? 1 Yes 2 No	Hospital: 111n	patient 2 🗆	ER/Outpatien	Otho	p.	ath <i>(Check only</i> Home 5 ☐ Res		Other (Specific	v)
ng Ph	ineral	J: T	27. Manner eath 1 1 Matural 5 ☐ Pending	28a. Date of	f Injury n, Day Year)	28b. Time of Injury	28c. Injury Work		28d. Describe			
tendi leath.	the fu	catic	2 Accident investigat 3 Suicide 6 Could not	6 -				es 2 □ No				
or All	in by	Certification:	4 ☐ Homicide determine	d 28e. Place o	of injury - At no g, etc. <i>(Specif</i> y	me, farm, stre	eet, factory, office			(Street and I wn, State)	Number or Rura	l Route Number,
spita nours	/ filled	a C	29a. Certifier 1 Certifying	Physician: To the b	best of my know	wledge, death	occurred at the tim	e, date and plac	e, and due to the	cause(s) a	nd manner as s	
he Ho in 24 h	pletel	edical	(Check only 2 Medical Ex	aminer: On the ba	sis of examinat	tion and/or in	vestigation, in my op	oinion, death occ	curred at the time	, date and p	lace, and due to	the cause(s)
To the position of the positio	Com	Σ	29b. Signature and title of certifier				29c. License	number		29d. Date	signed (Month,	Day, Year)
5			Mudy	au_	mp		VTZ	212		>661	18	2007
~			30. Name and address of person wh	o completed cause	of death (Item	23a) (Type, I	Print)	of Do	w/Garan	Cali	while 1	40 21041.
K of	Sta	te	31. Date filed (Month, Day, Year)	32 e	gistrar's Signal	ture	TAILUINT	77 1 161	- invally	Carini	nyIN /	2009 411 21844
R	egistr	ar	SEP 21	2007	eur L	× 190	enter)					

			1 - For State Registrar	State of Maryla		artment of H			ne 2007	32057
	Physici	ian	1. Decedent's Name (First, Middle, Last)					Date of Death     Month	Day Year	3. Time of Death
	/Media	cal			ross			September	23, 2007	
	Examir	ner	4a. Facility Name (If not institution, give s 34 High Street				Location of Death		4c. County of Death	
	Funeral		5. Social Security Number 6. Sex	7. Age (In vrs	. last birthday)	Boons If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	Washin 9. Birth	place (State or Foreign
	Director		214-28-0283 X	M 2□F 84	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, Xe AUGUST 3	,1923 Mar	yland
	pu s		Usual Residence of Decedent  10a. State 10b. County	10c C	ity, Town or Lo	antion				104 (-14-0)
	Maryli f eho	ō	Maryland Washing		oonsb					10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	128a-	rect	10e. Street and Number	10011	001135	10f. Zip Code		10g.	Citizen of What Cou	
	h with	O E	34 High Street			2171	13		U.S.A.	
	Itema ?	Funeral Director		Was Decedent Ever in U Armed Forces?	J.S. 13.		ispanic Origin? (Sp in, Mexican, Puerto	ecify Yes or No-	14. Race - Ameri	
36	or It		1 Never Married 2 Married	1X□Yes 2□No		1 ☐ Yes 💥 No		riioari, oto.)	Black, White	
21215-0036	within 72 hours after death with the Maryland ene. than "naturel", or Itema 23a or 28a-f ehow he Madical Exempler must be indiffied at	Completed by	3X Widowed 4 □ Divorced  15. Decedent's Educ	Year or Dates 1950-	-1951			400		hite
15	in 72 n "na Nadio	plet	(Specify only highest grade	completed)	(Give	lent's Usual Occupa kind of work done o DO NOT use retired	ation during most of work: f)	ing	o. Kind of Business/Ir	ndustry
212	filed withi Hygiene. ther than	Mo	Elementary/Secondary (0-12)	College (1-4or 5+)	C	onstructi	.on	Se	elf Employ	ed
ng	- 0	Be (	17. Father's Name (First, Middle, Last)	_			18. Mother's Name	(First, Middle, Mai	den Sumame)	
<u>yla</u>		<sup>L</sup>	Harry Elm				Hazel			Moser
Maryland	12 s h ar 7 le	gr i	19a. Informant's Name/Relationship (Typ. Alvin W. Gross						ity or Town, State, Zi	
	1 and 1 and 1 and 2 and 2 ther	1 8	20a. Method of Disposition	Son 20b.		Lgn Stree sition (Name of natory or other place		the second second second	land 2171 Location - City or T	
Baltimore,	o jo		X☐ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)			natory or other place Cemeter				
慧	permit. Pag Deportment Important: I any njury o		21. Signature of Funeral Service License						nsboro, M _	агутапо
m	Per men		D. hoel Bri	roly	Ai   41	ndrew K. D East An	tietam St	uneral Ho	ome, Inc. Jerstown, I	Md. 2174N
			23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	ations that caused the dea						Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Fungal	Sep	ficemia				Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consec	quence of):	chilic				
		er	Sequentially list conditions,	Due to (or as a donse	quence of):	iskitus			4	4 was
	cate be executed physician and the burial-transit	Examin	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Non	Hoda	Kin L	mpho	na		2 years
oʻ	a exec an an irial-tr	Exa	resulting in death) Last	Due to ter as a consec	The same		1 /			
8760,	death certificate be executed e attending physician and nd for use as the burial-transit	dical	L d	Prosp	are	Cancer				years.
9	death certific attending pl	/Med	IF FEMALE:	a life year outcome of process						
Вох	atten for us	clan	in the past 12 months?	c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of c	aldeath 3 🗆	Ectopic pregnancy Other (specify)			23d. Date of deliv Month	ery Day Year
0	함 후 하	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown	30um 5 [	Citier (specify)				
S,		by P	Part II. Other significant conditions conf	ributing to death but not re-	sulting in the ur	dertying cause give	en in Part I.	23e. Did tobaco	co use contribute to t	he cause of death?
ord	law requires as been sign 2 should be		mai	7)4777770	n			1 🗆 Yes	2 □ No 3 □ Prol	pably 4 Unknown
ec C	e law r has be	Completed	44	her tensio	n	. 11 .	1	24a. Was an autopsy	24b. Were auto	opsy findings available impletion of cause of
<u>=</u>	T age	Con	Chro	nic atrial	fibi	illatron	)	performed 1 ☐ Yes 2	? death?	2 □ No
žž.	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	spital:	· ·	Othe		(Check only one)		
of	Phys	. To	1 Yes 2 No	1 ☐ Inpatient 2 ☐ 28a. Date of Injury (Month, Day Year)	ER/Outpatien 28b. Time of	28c. Injury	4 1 Idui Sing Hor	ne 5 Residence 28d. Describe how in	6 Other (Special	( <del>ن</del> )
io	Attending r death.	atlor	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury		r? Yes 2 □ No		.,,	
Division of Vital Records,	I or Attendi after death. Director: A I in by the fu	Certification:	3 ☐ Surcide 6 ☐ Could not be determined	28e. Place of Injury - At h building, etc. (Speci	ome, farm, stre	et, factory, office		28f. Location (Street City or Town, St	and Number or Rura	al Route Number,
Ö	irs after ral Dir led in									
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical	29a. Certifier Check only one) Certifying Physical Examin	cian: To the best of my knows: On the basis of examina	owledge, death ation and/or inv	occurred at the tim estigation, in my op	e, date and place, a pinion, death occurr	and due to the cause ed at the time, date	e(s) and manner as s and place, and due to	itated. o the cause(s)
	To the Vithin 2 To the complet	Med	29b. Signature and title of certifier	and manner stated.		29c. License	number	2 <u>9</u> d.	Date signed (Month,	Day, Year)
)	- > - 0		12			144	996	Se	hlember	24,2007
			30. Name and address of person who co	ripleted cause of death (Iter	п <sub>и</sub> 3а) (Тура) I	Print an ha	ncla	Roman	'n a Mh	24,2007
31-	1-3+1		31 Date filed (Aforth Day Yard)	IK MD	W >//	יטוןיוי	14	v sounsy		7/10
	Sta Registr	te ar	31. Date filed (Month, Day, Year) SEP 2 5 20	32. Registrar's Signa	11.	wills.				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** 2046 18 Eugene Lawrence Hedgpeth September 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Holy Cross Hospital Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1 X M 2 □ F Yrs. Director North Carolina 243-50-4442 71 November 6, 1935 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State ral", or Items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 ☑ No Directo Maryland Prince George's Adelphi 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8803 Riggs Road 20783 U.S.A. Funeral death 12. Was Decedent Ever in U.S. Armed Forces?

1 ☑ Yes 2 ☐ No If Yes, Give . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 ☐ Never Married 2 3 Married 3altimore, Maryland 21215-0036 'natural", or 1 ☐ Yes 2 ☒ No Specify. American Indian year or Dates: Unknown ģ 3 ☐ Widowed 4 ☐ Divorced 12 Shours to an and Mental Hygiene.
27 Is marked other than "natural" Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 10 Bridge Division Inspector 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဥ Merzie M. Hedgpeth Vernetta A. Lynch 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 Is any injury or other trains Helen Hedgpeth - Wife 8803 Riggs Road, Adelphi, Maryland 20783 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Dother (Specify) George Washington Cemetery 9/22/2007 Adelphi, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 23a. Part1. Enter the disease, or complications that caused the dath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Myelodysplasia Syndrome End Stage /Medical resulting in death) Due to (or as a consequence of): Examiner Pancyto enia Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine as the burial-transit death certificate be executed Malnutrition that initiated events resulting in death) Last and Due to (or as a consequence of) P.O. Box 68760. physician Physician/Medical Atrial Fibrillation attending for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, \$ 1 Tyes 2 No 3 Probably 4 NUnknown Completed peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performe 2 No 1 ☐ Yes 2□ No or Attending Physician: director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA P 27. Manner of Death 28a. Date of Injury 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation (Month, Day Year) 1 X Natural Injury 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director; \
completely filled in by the f 2 Accident 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide the Hospital 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified 2 D64189 September 19, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year) SEP 2 1 2007

Rama Kapoor, M.D., 1500 Forest Glen Road, Silver Spring, Maryland

32 Registrar's Signature

State Registrar 31. Date filed (Month, Day, Year)

SEP 2 6 2007

DHMH 17 Rev 1/2001

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) September 18, 2007 Physician 9:00 Gene Miller Hollis /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel Heritage Harbour Health & Rehab Annapolis If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 9. Birthplace (State or Foreign Country) Maryland 8. Date of Birth (Month, Day, Nov. 13, 7. Age (In yrs. last birthday) 5. Social Security Number Funeral 1 □ M 1914 92 Director 214-10-5378 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County YYes 2 □ No

Annapolis

12. Was Decedent Ever in U.S. Armed Forces?

10f. Zip Code

21403

Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

10g. Citizen of What Country?

14. Race - American Indian,

Black, White, etc.

United States

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must he market and once. Baltimore, Maryland 21215-0036

Director

uneral

Maryland

11. Marital Status

10e. Street and Number

1300 Hilltop Lane

Anne Arundel

Physician /Medical **Examiner** 

To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transigned by the a d be detached f within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

Division or Vital Records, P.O. Box 68760,

	by Fi	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes Y No If Yes, Give Year or Dates:		1 ☐ Yes 2	X∏No Specii	fy:		Specify: W	hite		
1	Completed	15. Decedent's Edu (Specify only highest grad	e completed)	16a.	Decedent's Usua (Give kind of wor life. DO NOT us	l Occupation k done during me e retired)	ost of workin	g 16b. h	Kind of Business	/Industry		
	d L	Elementary/Secondary (0-12)	College (1-4or 5+) 4		dminist			l	leral Go	vernment		
	Be C	17. Father's Name (First, Middle, Last)					*	(First, Middle, Maide				
	To B	Leslie O'Neil Mill	er			Nel1	lie Ma	y Zerick				
		19a. Informant's Name/Relationship (Ty	pe. Print)	19b.	Mailing Address	(Street and Num	ber or Rural	Route Number, City	or Town, State,	Zip Code)		
		H. Emerson Blake /			08 Long			at Barring				
		20a. Method of Disposition  1 □ Burial 2 □ Cremation 3 □ E	Removal from State	20b. Place of cemeter	Disposition (Nam y, crematory or o	e of her place)	Da	ate 20c. L	ocation - City or	Town, State		
		1 ☐ Burial 2√ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)		Baltin	nore Cre					Maryland		
ouce.		21. Signature of Funeral Service Licens	ee							al Home, Inc , MD 21401		
		23a. Part1. Enter the disease, or compl shock, or heart failure. List only or	ications that caused the	e death. Do n						Approximate Interval Between		
ın		Immediate Cause (Final disease or condition	le cause on each line.	Crook	lino	Anyll	DILLE			Onset and Death		
al		resulting in death)	a Due to (or as a c	onsequence o	of):	- 1	000					
er		Sequentially list conditions										
2	iner	Sequentially list conditions, if any, leading to improduce cause. Enter Underlying Cause (Disease or injury that initiated events cause.										
d	Examiner	Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):										
	E	Dub to for as a sortoqueries off.										
	dic	d.										
W	an/Me	23b. was decedent pregnant	pregnancy □Fetal death	3 □Ectopic pr	eanancv		,	23d. Date of de	livery Day Year			
	by Physician/Medical	in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	4□Pregnant at tin 9□Unknown		5 ☐ Other (sp	ner (specify)						
	/ Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										
	d b	- Ja	failed to thrue 1 Yes 2 No 3 Probably 4 Jun									
	Completed	D	Molier .					24a, Was an	24b. Were a	utopsy findings available		
	шо							autopsy performed? 1☐ Yes	death?	completion of cause of s 2 □ No		
	Be C	25. Was case referred to medical				26. Pla	26. Place of Death Check onl one					
П	To B	examiner? 1 ☐ Yes 🖭 No	Hospital: 1 ☐ Inpatient	2 🗆 ER/Ou			Nursing Hon	ne 5 🗆 Residence	6 □Other (Sp	ecify)		
	:uc	27. Manper of Death  Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Y			8c. Injury at Work?		8d. Describe how inj	ury occurred			
	catio	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	28e. Place of injury		M	1 ☐ Yes 2		Of Landing (Carent		Sured Florida Mumbar		
	ertification:	4 Homicide determined	28f. Location (Street and Number or Rural Route Number, City or Town, State)									
	0	29a. Certifier (Check only) 2 Medical Exam	vsician: To the best of i	my knowledge xamination an	, death occurred d/or investigation	at the time, date	and place, a	and due to the cause ed at the time, date a	(s) and manner a and place, and du	as stated. ue to the cause(s)		
	Medical	one)	and manner state			. License numbe			ate signed (Mor			
	2	29b. Signature and title of certifier			200	D -	7 07 0		9-18-			
				W. //h 00-1	Time Dri-4	135	TUL 8		1 10	0 7		
		30. Name and address of person who c	ompleted cause of deal	in (item 23a) (	Type, Print)	lacly.	Ave.	#231 A	4nnapol	is, MD21410)		
Sta		31. Date filed (Month, Day, Year) SEP 2 0 20		s Signature	bout	,						
istı	ar	SET & U ZU	01		141							

Registrar

07-07569 Daria Hardin Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

na narum		-For State Of Maryland / Department of Health and Mentan	Reg. No. 20	07 3206
Physician	1	legistrar 1. Decedent's Name (First, Middle,Last)	2. Date of Death	3. Time of Death
edical Examine	ŧΓ	Daria Dittmer Hardin	September 26, 2007	1451 hrs
7		4a. Facility Name (if not institution, give street and number)  Anne Arundel Medical Center  4b. City, Town, or Location of Dea  Annapolis	Anne Arundel	
Funeral Director		391-20-1008 1 N 2X F 38 Yrs.	fin Forei	
w any	-	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location  MD Anne Arunde1 Annapolis		10d. Inside City Limits 1 Yes 2XX No
Maryland - 28a-f she	ופ	10e. Street and Number 10f. Zip Code	10g. Citizen of What Cou	
with the		104 Pine Dr. 21403  11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Alternative Decedent Control Decede		rican Indian, Black,
after death	by runeral	1 Never Married 2 X Married Armed Forces? 1 Yes 2X No 3 Widowed 4 Divorced If Yes, Give Yeer or Dates:  1 Yes 2 X No specify:		iite
2 hour	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4 or 5+)  5+  Urban Planner		
21215-0036 21215-0036 Mental Hygiene. marked other than ic event, the Medica	E -		ime (First, Middle, Maiden Sumame)	Timent
1215 d be file lental H arrked o	8	Terrance Dictmer	ochelle Brown	a Zin Code)
MD 2 id 2 shoul lith and M m 27 is m aumatic		William E. Hardin Husband 104 Pine Dr. Annap	olis, MD 21403	
Baltimore, permit. Pages I an Department of Heal Important: If iten injury or other tra		4 Donation 5 Other Specify:	Date 20c. Location - City of Date 20c. Baltimore	, MD
Baltimo permit. Page Department or Important: injury or oth		21. Signature of Puneral Service Licensee 22. Name and Address of Facility H  12 Ridgely Ave.	ardesty Funeral Hom Annapolis, MD 21401	ne, P.A.
Physician /Medical		23a. Part i. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardia failure. List only one cause on each line.	ac or respiratory arrest, shock, or heart	Approximate Interval Between Onset and Death
taminer		Immediate Cause (Final disease or condition resulting in death)  a. Complications of Liver tumor  Due to (or as a consequence of):  b.		
	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated		
ecuted and - transit		events resulting in death) Last  Due to (or as a consequence of):  d.		
60, ate be exe ohysician a	Medical	X MENDED X #Z3a,23c,23d,27,perME,g872, 10/9/07 TT	22d Date of deliver	an.
Box 6876  e death certificate the attending phy ed for use as the t	Physician/M	1 FEMALE:   23b. Was decedent pregnant in the past 12 months?   1 X Live birth   2 Fetal death   3 Ectopic pregnant at time of death   5 X Other (Specify) Twins, one	deceased	Day Year
J. Boy t the death by the att	Physi	1 X Yes 2 No 9 Unknown g Unknown  Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	July 7, 20	
ires that to signed by defeace	اھ	Stationary to down out for fooding it the disconying states given in out to	1 Yes 2 No 3 P	obably 4 V Unknown
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Fineral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transitions.	Completed			
tal Rectian: The	ğ Be	25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other No.		
n of Vital I ling Physician: After this certifi funeral director,	의	27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work?	28d. Describe how injury occurred	ner:
ion C Itending teath. tor: Af	ation	1 X Natural 5 Pending (Month, Dey,Yeer) 1 Yes 2 No		
Divis spital or At tours after d teral Direct filled in by	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or or Town, State)	Rural Route Number, City
Divisior To the Hospital or Attend within 24 hours after death To the Fineral Director: completely filled in by the	Medical C	2ga. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, one)  Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	and due to the cause(s) and manner as s red at the time, date and place, and due to	tated. the cause(s)
5. ≥ 5. 8	Re	29b. Signature and title of certifier  29c. License number  O.C.M.E.	29d. Date signed <i>(t</i> September 27,	•
		30. Name and address of person who completed cause of death (Item 23a)		
/4/		Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 231. Date filed (Month, Day, Year) 32. Registrar's Signature	1201	
Sta Registi		OCT 0 2 2007		

OCME

			For 1 _ State	State of Ma	aryland					ental Hyg	giene	7007	22062	
*			Registrar  1. Decedent's Name (First, Middle	- 1001)		Cei	rtificate of I	Death		2. Date of Dea		2007		
	Physici	an	George Irvin			Month Day Year			3. Time of Death					
il.	/Medio		4a. Facility Name (If not institution				4b. City, Town, or	r Location		Sept.		2007 County of Deatl	9:06 p <sup>M</sup>	
-	LAdiiiii	CI	Calvert Nurs	ing Center			Prince	Fred	derio	ck		Calv	ert	
8.	Funeral		5. Social Security Number			ast birthday)	If Under 1 Year Months Days	If Under Hours		8. Date of Birth (Month, Day	ı, Year)		nplace (State or Foreign untry)	
200	Director		218-30-4370 Usual Residence of Decedent	IMIN SELF	75	Yrs.				5/10/1	1932		MD	
	land ow		10a. State 10b. County		10c. City,	Town or Lo	cation			<del></del>			10d. Inside City Limits	
	Mary P-f sh	tor	MD Ca	lvert			Prince	Fred	eric	k			1 X Yes 2 □ No	
	or 28	Director	10e. Street and Number			-	10f. Zip Code				10g. Citiz	en of What Co	untry?	
	ath wi	ral	85 Hospital				20	678				USA		
	er deg	Funeral	11. Marital Status	12. Was Decedent Armed Forces?		S. 13. \	Was Decedent of H f Yes, specify Cuba	lispanic Ori an, Mexical	igin? (Spe n, Puerto F	cify Yes or No- Rican, etc.)	1	<ol> <li>Race - Amer Black, White</li> </ol>		
36	irs aft Xami	by F	1 ☐ Never Married 2 ☐ Marr 3 🔯 Widowed 4 ☐ Divorced	ied 1 ☐ Yes 2 🔯 l If Yes, Give Year or Dates:	NO		1 ☐ Yes 2 💢 No	Specify:				Specify:	Black	
21215-0036	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or Items 23a or 28a-f show ont, the Medical Examiner must be notified at	ted	15. Deceden	t's Education		16a. Deced	dent's Usual Occup	ation			16b. Kir	nd of Business/I		
218	thin 7 ee. an "n	Completed	Elementary/Secondary (0-12)	st grade completed)  College (1-4or 5	5+)	life. I	kind of work done of DO NOT use retired	auring mos d)	st of workir	ng		- · · · · · · · ·		
	led will have her the her the her the her the		3	10			Farmer			(F: 1 14:11)		Farmin	9	
and	ntal ⊦ ed otl	Be	17. Father's Name ( <i>First, Middle,</i> Phillip Harr	,						(First, Middle, Giles	Maiden (	Surname)		
Maryland	s i and 2 should be filed within 72 hours after death with the Marylar if Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	2	19a. Informant's Name/Relations			19b. Mailin	g Address (Street				r. City or	Town State Z	(in Code)	
	if and 2 if Health ar tem 27 is other trau		Brenda Smith			1	L Chestn				-			
Je,	of Hear of Hear item		20a. Method of Disposition	·	20b. Pla	ace of Dispo	sition (Name of natory or other place	i		ate		cation - City or		
Ē	Page ment ant: If ury o		1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		Che	esape	ake Cre	m.	10/1	/07 E	3elt	sville	e, MD	
Baltimore,	permit. Pages 1 and 2 Department of Health s Important: If item 27 is any Injury or other tra once.		21, Signature of Funeral Service	over the second		1	Name and Address O Box 4		nα				, P.A.	
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that caused only one cause on each lir	I the death.	. Do not ent	er the mode of dyin	ng, such as	cardiac o	r respiratory ar	rest,		Approximate Interval Between	
	Physician		Immediate Cause (Final disease or condition resulting in death)	_a. 5	rok	e_	(CVA	)					Onset and Death	
	/Medical Examiner		resulting in death)	Due to (or as	a conseque	ence of):	_	/						
deligner	A. 4	e	Sequentially list conditions, if any, leading to immediate	b. Due to (or as	a conseque	ence of):								
	uted d ansit	Examiner	Cause (Disease or injury that initiated events	G										
oʻ	an an arrial-tr	Exa	resulting in death) Last	Due to (or as	a conseque	ence of):								
38760,	cate be executed physician and the burial-transit	dical		d										
•		/Med	IF FEMALE:	23c. If yes, outcome	nf pregnar	ncv.					1.			
Box	death certiff e attending d for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant at	2 Fetal	death 3□	Ectopic pregnancy Other (specify)	/			2	3d. Date of deli Month	very Day Year	
0	0 0	ıysi	1 □ Yes 2 □ No 9 □ Unknown	9□Unknown			2 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0							
S, P	The law requires that the ate has been signed by the bage 2 should be detache	by PI	Part II. Other significant condition	ons contributing to death be	ut not resul	lting in the ur	nderlying cause give	en in Part I		23e. Did to	bacco us	cco use contribute to the cause of death?		
Records,	w require been sig should b		HW							1782	es 2[	No 3∏ Pro	obably 4 □Unknown	
ecc	ne law r has be ge 2 sh	Completed	Diabe	tes, Type	_ 2					24a. Was a	sv	24b. Were au	topsy findings available completion of cause of	
		Con	Tobac	co Addic	Bor	1				perfor 1□ Yes	med? 2 No	death? 1 ☐ Yes	2 □ No	
or Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medica examiner?  1 ☐ Yes 2♥ No	Hospital:			A OFFICE Other			(Check only or				
		1: To	1 ☐ Yes 25 No 27. Manner of Death	1 ☐ Inpatie	ry	R/Outpatien 28b. Time of	28c. Injur	v at		ne 5 ∐ Resid 8d. Describe h		Other (Spec	cify)	
Division	Attending Ph r death. ector: After th by the funeral	Certification:	1 Natural 5 Pendin 2 Accident investig		y Year)	Injury	Morl M 1 □	ƙ? Yes 2 □	No					
Vis	il or Attend after death. Director: A d in by the fi	tifica	3 Suicide 6 Could of determ	not be 28e. Place of injuined building, etc	ury - At hor	me, farm, str	eet, factory, office		2	8f. Location (S City or Tow	treet and	d Number or Ru	ral Route Number,	
	ital or A	Cer												
	To the Hospital or Al within 24 hours after d To the Funeral Direct completely filled in by	Medical		ng Physician: To the best of Examiner: On the basis of and manner sta	f examinati									
	To the within To the Somple	Me	29b. Signature and title of certifie				29c. License	e number		2	29d. Date	e signed (Month	n, Day, Year)	
	- 1		1/4	M	· A.		D	519	49		91	24/	7	
. 1			30. Name and address of person	who ampleted cause of d	eath (Item :	23a) (Type,	Print)	01		٠,	7	40	1	
RN	I		Davi	a Callar	24	110	Print) Hospital	Rd,	Su	te 310	for.	nce to	redealle MO	
	Sta		31. Date filed (Month, Day, Year)	2 4 2007	s Signati	ure K	boothe	, ′					2067	
	Registr				- HERMAN		100							

DHMH 17 Rev 1/2001

**OCME** 

ORIGINAL

		For State Registrar	State of	Marylan			nt of Hea te of De		Mental Hyg	giene Reg. N2 () (	07	32064
. D.		1. Decedent's Name (First, Midd	fle, Last)					-	2. Date of Dea	ath Day	Year	3. Time of Death
Physic /Med		Nancy	J		Hab	ibi			Sept.	25	2007	4:00p <sup>M</sup>
Exami		4a. Facility Name (If not institution	on, give street and num	ber)		4b. City	, Town, or Loc	ation of Death			y of Death	
		Potomac Valley					ockvill	P Jnder 24 Hrs.	Data of Bird		tgome	
Funeral		5. Social Security Number	6. Sex 7 1  M 2  F	Age (In yrs.	<i>last οιπησαγ)</i> Yrs.	Months		ours Min.	8. Date of Birt	y, Year)	Cou	place (State or Foreign ntry)  ington, DC
Director		225-50-9342 Usual Residence of Decedent		69					Jan. 2	<b>7,</b> 1930	Wasi	migton, be
yland		10a. State 10b. Count	у		y, Town or Lo							10d. Inside City Limits
Mar a-1-e	ctor	MD Mon	tgomery	R	ockvi1	le.						1 ☐ Yes 2 ☐ No
h with the 23a or 28 at be no	Funeral Director	10e. Street and Number 1235 Potomac V	alley Road				p Code <b>20850</b>			10g. Citizen of <b>USA</b>	What Cou	ntry?
id yidilid Z 12.13-0000 2 should be filed within 72 hours after deeth with the Maryland and Mental Hygiene an marked other then "natural", or flema 23a or 28a-f show aumatic event, the Modical Examinant or notified	d by Funer	11. Marital Status  1 Never Married 2 Maried 3 Widowed 4 Divorce	If Yes, Give	ces? 2 <b>™</b> No		Was Dece If Yes, spi 1 🗆 Yes	ecity Cuban, N	nic Origin? (S) lexican, Puerti pecify:	pecify Yes or No o Rican, etc.)	Spec		etc. ite
IMBLY ISING C 1.2.15-0050 d 2 should be filed within 72 hours all th and Mental Hygiene. t7 le marked other then "natural", or traumatic event, the Munical Exern traumatic event.	Completed		ent's Education est grade completed) College (1-	4or 5+)	(Give	kind of w	ial Occupation ork done durin use retired)		king	16b. Kind of		
filed w Hygier bither th	Co	12	2		Admin	. As	sistan		no (First Middle			ernment
De fil	Be	17. Father's Name (First, Middle							ne (First, Middle,	маювп Бита	me)	
re, Maryla s 1 and 2 should f Health and Men Item 27 le marke	မှ	Burdette Warde			10h Maili	na Addroi			Richter	or City or Tow	n State Zi	n Code)
d 2 st d 2 st th an 7 le r traur		Mina Habibi -	W. Sali			•	Grass			dbride		22192
C = 1.4 F		20a. Method of Disposition	Daugnter	20b. F	Place of Dispo	sition (Na	ame of	Court	Date	20c. Location	-	
00		1 Surial 2 Cremation 4 Donation 5 Other		tate	erling			10/01	/2007	Ster1	ing,	VΑ
baltimo permit. Page Depertment a Important: if eny injury o		21. Signature of Funeral Service			2:	2. Name a	and Address of	Facility	1 Home	721 I	Ilden	St.
		23a Part 1 Enter the Historia	or complications that ca	used the deat				-			ion, v	7A 20170 Approximate
Physician		23a. Part1. Enter the disease, shock, or heart failure. Li Immediate Cause (Final	st only one cause on ea	ich line.	1	^	east					Interval Between Onset and Death
cate be executed physicien and physicien and sthe burial-transit		resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. — Due to (c	or as a consec or as a consec or as a consec	quence of).							
The Cords, P.O. DOX 06/00,  The law requires that the death certificate be executed ten has been signed by the attending physicien and pege 2 should be detached for use as the burial-transit.	by Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1									23d. Date of delivery  Month Day Year	
COTOS, P. w requires that ( been signed by should be deta		Part If. Other significant condi	itions contributing to de	ntributing to death but not resulting in the underlying cause given in Part I.					3e. Did tobacco use contribute to the cause of death			
DIVISION OF VITAL HECOFGS, It or Attending Physician: The law requires to after death.  Director: Atter this certificate has been signed in by the funeral director, page 2 should be to a line by the funeral director, page 2 should be to a line by the funeral director.	Completed	24a. Was an autopsy performed?									prior to c death?	opsy findings available ompletion of cause of
	0	25. Was case referred to media	cal				26	Place of Do	1 Yes	2 No	1 LJ Yes	2□ No
Of VITA Physician: rthis certific	To B	examiner? 1 ☐ Yes 2X No	Hospital:	npatient 2	] ER/Outpatie	nt 3 🗆 🗈	Other				ther (Spec	ifv)
On Or ding Phy h. After thii funeral c		27. Manner of Death	28a. Date o	nt Injury h, Day Year)	28b. Time o Injury		28c. Injury at Work?	Nursing Home 5 Residence 6 Other (Specify)  28d. Describe how injury occurred				
DIVISION Of VITA  To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: Attenthis certific completely filled in by the funeral director,	Certification:	3 Suicide 6 Coul	ld not be 28e, Place	of Injury - At h ng, etc. (Speci	iome, farm, si	reet, facto	ry, office			Street and Nut wn, State)	mber or Ru	ral Route Number,
Hospital 24 hours a Funeral (	edical C	29a. Certifier 1X Certify (Check only one)	ying Physician: To the al Examiner: On the ba and mann	isis of examina	owledge, dea ation and/or in	th occurre	d at the time, on, in my opini	date and place on, death occu	e, and due to the urred at the time,	cause(s) and date and plac	manner as e, and due	stated. to the cause(s)
To the within 2 To the complet	₩ E	29b. Signatus and title of certi		WORK.		2	9c. License no	ımber		29d. Date sig	ned (Monti	, Day, Year)
r s r 0		1 / truce	roller	alto		1	382	62		Sent	26	7007
lo		30. Name and address of person	on who completed cause		m 23a) (Type	, Print)	arch	BLVI	) Sial	5 330	o Roc	20850 kulle mp
Regis	tate trar	31. Date filed (Month, Day, Ye.	2007 32. R	egistrar's Sign	ature	R)						

			1 - For State Registrar	State of Marylan	id / Depa <i>Cei</i>	irtment of F tificate of	lealth and Me Death	ental Hygie	2007	32065
	DI ···		Decedent's Name (First, Middle, La.	st)				2. Date of Death Month	Day Year	3. Time of Death
	Physici /Medio		Tammy Leigh	McClain	Hiln	brand			er 24, 200	7:10 a <sup>M</sup>
	Examin		4a. Facility Name (If not institution, give	e street and number)		4b. City, Town, o	r Location of Death		4c. County of Death	n
			Anne Arundel Medi			Annapo			Anne Arı	
	Funeral		5. Social Security Number 6. S 220-88-4794	□M 2XTE	(ast birthday) Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day, Y	(ear) 9. Birth	nplace (State or Foreign untry)
H.	Director		Usual Residence of Decedent	43	113.			Aug. 31,	1964 Penr	nsylvania
	yland yow		10a. State 10b. County		y, Town or Lo	cation				10d. Inside City Limits
	Man	to	MD Calver	ct Che	esapeal	ke Beach				1 X Yes 2 □ No
	h the	lrec	10e. Street and Number			10f. Zip Code		10g	. Citizen of What Cou	untry?
	72 hours after deeth with the Maryland natural; or Iteme 23s or 28s-f ehow acat Examiner must be notified a	Funeral Director	3512 Elizabeth	Court		2073	32		U.S.A.	
	eep .	Iner	11. Maritaf Status	12. Was Decedent Ever in U. Armed Forces?	.S. 13. \	Vas Decedent of H	ispanic Origin? (Spec an, Mexican, Puerto R	rify Yes or No-	14. Race - Amer Black, White	
õ	or It		1 ☐ Never Married 2 X Married	1 ☐ Yes 2 No		☐ Yes 21 No	Specify:	,		hite
Ś	urai'.	d by	3 Widowed 4 Divorced	Year or Dates:			- · · · ·			
င်	n 72 "nat	Completed	15. Decedent's Ed (Specify only highest gra	ducation de completed)	(Give	lent's Usuaf Occup kind of work done of DO NOT use retired	during most of workin	g 16	b. Kind of Business/I	ndustry
7	withii than	mc	Elementary/Secondary (0-12)	College (1-4or 5+)		- opera		G:	andwich s	shop
7 5	filed Hygi Sther ent,	ပိ	17. Father's Name (First, Middle, Last)		OWICI	- Opera	18. Mother's Name			ыор
	d be ental Ked of	To Be	Robert John	McClain			Marjor	ie Kay	Weyer	
<u> </u>	Shound M	-	19a. Informant's Name/Relationship (	Type, Print)	19b. Mailin	g Address (Street	and Number or Rural	<del>-</del> -	ity or Town, State, Z.	ip Code)
Ě	alth a		Robert J. McClair	, father	3512	Elixabet	h Ct., Che	esapeake	Beach, MI	20732
กั	of Heritem		20a. Method of Disposition	20b. P		sition (Name of natory or other place			c. Location - City or 1	
altimo	Page nent c int: if		1 ☐ Burial 2 🌠 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	memoval itom State			atory 10-0	)1-07 Al	lexandria.	VA
= = =	permit. Pages 1 end 2 should be filed within 72 hours after deeth with the Marylan Deperment of Health and Mental Hygiene. Important: if time 27 is marked other than "natural; or treme 23a or 28a-f show eny injury or other traumatic event, the Macical Examinar must be notified at once.	-	21. Signature of Funeral Service Light			. Name and Addre			eral Home,	
۵	80 E 5 8		Dexa 1	reebach	83	325 Mt. H	armony Lar			736
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the death	h. Do not ente	er the mode of dyin	g, such as cardiac or	respiratory arrest		Approximate Interval Between
F	Physician		Immediate Cause (Final disease or condition	Coerd	1000	Amolto	MIG		k .	Onset and Death
	/Medical		resulting in death)	Due to (or as a conseq	uence of):	t	1119			
	Examiner		Sequentially list conditions.	b						
. 1	p ts	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequ	uanea of).					
74	end Frran	хап	that initiated events resulting in death) Last	uence of):		<del></del>				
0000	icate be executed physicien end s the burial-transIt	ai E		200 (0) 20 2 00,000	001100 017.					
	icate phys s the	edicai		. d						
<b>X</b>	eath certifi ettending I for use as		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna					23d. Date of delin	verv
<u> </u>	death d for	cia	in the past 12 moords? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of d		Ectopic pregnancy Other (specify)			Month	Day Year
į	t the	Physician/M	9 Unknown	9□ Unknown						
'n	w requires that the death certif been signed by the ettending should be detached for use a	by P	Part II. Other significant conditions of	· ·	ulting in the ur	derlying cause give	en in Part f.	23e. Did tobac	cco use contribute to	the cause of death?
5	aquire en sig	ed	Ula TITION	IC Brain	111	wy.		1 🗆 Yes	2 □ No 3 □ Pro	obably 4 Onknown
֝֟֝֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֡֓֓֡֓֓֓֓֓֡֓֓֡	lawr as be 2 sh	pie				/		24a. Was an autopsy	24b. Were aut	topsy findings available
<u>.</u>	The ete h	Completed						performed	d? / death?	2 No
<u>.</u>	sian: artific ctor.	Be (	25. Was case referred to medical examiner?		/		26. Place of Death			
	hysic his o	ဥ	1 ☐ Yes 2 No	Hospital: 1 ☐ Inpatient 2			4 U Nursing Hom	e 5 🗆 Residenc	e 6 □Other (Spec	afy)
	ing P	ë	27. Manner of Death ↓ ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injun Worl		3d. Describe how	injury occurred	
2	tend death tor: /	cati	2 Accident investigation 3 Suicide 6 Could not be				Yes 2 □ No			
	or A after Direc in by	Certification	4 Homicide determined	28e. Pface of Injury - At he building, etc. (Specify	ome, tarm, stre	eet, factory, office	28	City or Town, S	et and Number or Ru State)	ral Houte Number,
•	pital ours cours corel		29a, Certifier Voorlifying Ph	ysician: To the best of my kno	wledge death	cooursed at the time	no date and place, as	ad due to the gaus	co(s) and manner as	etated
:	To the Hospital or Attending Physician: The law requires thet the death certil within 24 hours either death. within 24 hours either death. To the Funeriel Director: After this certificete has been signed by the ettending completely filled in by the funeral director; page 2 should be detached for use a	Medical	(Check only 2 Nedical Examone)	niner: On the basis of examinal and manner stated.	tion and/or inv	estigation, in my of	pinion, death occurred	d at the time, date	and place, and due	to the cause(s)
	To the	Me	29b. Signature and title of certifier	0 04 -	01	29c. License	e number	29d.	. Date signed (Month	, Day, Year)
				Holelya 1	Inch	a no	7028		9/24/20	07
	11		30. Name and address of person who	completed cause of death (fter	1 23a) (Type,	Print)	, , ,		1- 1/00	
	4		Aditya Chor	ora 2001 M	edical	PARKA	way Ar	neipoli	s, Md. 2	1401
	Sta		31. Date filed (Month, Day Year)	2007 32 Angistrar's Signa				U		
	Registr	ar	30.00		0					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) September 13, 2007 **Physician** Albert S. Jackson, Jr. 5:35 P M /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** 1100 Carrington Avenue Capitol Heights Prince George's If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours tv∑M 2□ F 578-80-6121 50 Director April 4, 1957 Washington, DC Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits f show r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1,□Yes 2□No Directo Maryland Prince George's Capitol Heights 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1100 Carrington Avenue Funeral 20743 death <u>United States</u> 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. Black, White, etc. filed within 72 hours after 1 Yes 27 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: ģ Specify: 3 ☐ Widowed 4 🖾 Divorced Black Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 3 College (1-4or 5+) n and Mental Hygiene. Elementary/Secondary (0-12) Bus Driver permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygie. Important: If Item 27 is marked other th any injury or other traumatic event, the once. Private 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Albert S. Jackson, Sr. Jean Fairfax 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jean D. Jackson - Mother 1100 Carrington Ave. Capitol Heights, MD 20743 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Other (Specify) Resurrection Cemetery Sept. 25, 2007 Clinton, MD 21. Signature of Funeral Service License. 22. Name and Address of Facility Stewart Funeral Home, Inc. 4001 Benning Road, NE Washington, DC 20019 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** CANCER OF THE BILLARY TRACT /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): physician and s the burlal-transit law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical as the ed by the attending detached for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an Were autopsy findings available prior to completion of cause of autopsy perform death? 1 ☐ Yes 2 ☐ No 2 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2**M** No 1 ☐ Yes 2 ER/Outpatient 3 DOA Certification: To 1 ☐ Inpatient After this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) nours after death.
Ineral Director; After t 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending Injury investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Division or Vital Records, Hospitai

P.O. Box 68760,

Saltimore, Maryland 21215-0036

within 24 hours a To the Funeral L Medical Registrar

SEP 2 4 2007 31. Date filed (Month,

29b. Signature and title of certifier

emperixona MO

30. Name and a ress of person who completed cause of death (Item 23a) (Type, Print)

29a. Certifier

(Check only one)

9940 FRANKLIN SQUARE DR-BALTIMORE, MD. 21236 C. VERGARA-SOARES 32. Registrar's Signa

DHMH 17 Rev 1/2001

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

September 20, 2007

			For State Registrar	State of Maryland		rtment of H tificate of L			2007	32067	
			1. Decedent's Name (First, Middle, Last)					2. Date of Death Month	Day Year	3. Time of Death	
	Physicia /Medic		Joyce H.	Johnson					18, 2007	4:50 A M	
*	Examin		4a. Facility Name (If not institution, give s			4b. City, Town, or	Location of Death		4c. County of Deatl	h	
			St. Thomas More N			Hyattsv If Under 1 Year	rille If Under 24 Hrs.	0.0.40:45		George's	
	Funeral Director		5. Social Security Number 6. Sex 1579-30-8781	7. Age (In yrs. last	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, Y		nplace (State or Foreign untry)	
			Usual Residence of Decedent	00				ADITT 19,	1919 Uni	on, sc	
	ylanc		10a. State 10b. County	10c. City, T	Town or Loc	ation				10d. Inside City Limits	
:	e Ma	ctor	Maryland Prince G	George's Hyat	tsvil	1e				1☆ Yes 2 No	
3	e 22	Directo	10e. Street and Number			10f. Zip Code		10g	. Citizen of What Co	untry?	
	a 23e	rai	4922 LaSalle Road	10 111-0	40.14	20782	0-1-1-0/0-	1	nited Sta		
	Iten de	Funerai	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No	13. W	Yes, specify Cuba	spanic Origin? (Spe n, Mexican, Puerto I	Rican, etc.)	Black, White		
)36 )	urs af	þ	3 ☑ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1	☐ Yes 21☑ No	Specify:		Specify: B1	ack	
Ö,	within 72 hours after deeth with the Maryland ene. Then "natural", or Items 23e or 28s-f show the Medical Examiner must be colified at	Completed	15. Decedent's Educ			ent's Usual Occupa	ition furing most of worki		b. Kind of Business/	Industry	
7	ithin	npie	Elementary/Secondary (0-12)	College (1-4or 5+)	life. D	O NOT use retired,	) -	<i>'</i> 9			
7	ygien ygien tt.		12 years		Re	ceptionis	-	(Ci-1 14:14)- 14-	Private		
Maryland 21215-0036	De fil	Be	17. Father's Name (First, Middle, Last)  Reginald G. Youn	10			18. Mother's Name	(First, Middle, Ma H. Willia			
2	hould d Me mark matic	မှ	19a. Informant's Name/Relationship (Ty)		19h Mailini	Address (Street a			City or Town, State, Z	Zip Code)	
S ∶	nd 2 solution and 2 solution are 27 is rither		Jacqueline Y. Sim	1					VA 22306		
e,	of Hee		20a. Method of Disposition	cem	e of Dispos	ition (Name of atory or other place		ate 20	c. Location - City or	Town, State	
<u>Ĕ</u>	Page ment ant: if ury o		1 ☐ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	Park		Cemetery	-		Rockville		
Baltimore,	permit. Pages 1 end 2 should be filed within 72 hours after deeth with the Marylan Department of Heelint and Mental Hygiene. Department of Heelint and Mental Hygiene. Important: If Item 27 is marked other then "natural; or items 23e or 28e-1 show eny injury or other treumatic event, it Madical Examiner must be notified at once.		21. Signature of Funeral Service Licens	Clarati	/1/1				eral Home ngton, DC		
			23a. Part1. Enter the disease, or compli- shock, or heart failure. List only or	ications that caused the death.	Do not ente	r the mode of dying	g, such as cardiac o	r respiratory arres	ι,	Approximate Interval Between Onset and Death Years	
	nysician /Medical Examiner		Immediate Cause (Final Multi Organ Failure								
			resulting in death)	Due to (or as a consequen							
	LAGIIIIICI	<u>.</u>	Sequentially list nonditions b	Cerebro Vas		Acciden	IT.			Years	
	nsit	nine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to tor as a consequen	ice or).						
Ć	execunand in and ial-tra	Examiner	that initiated events resulting in death) Last	Due to (or as a consequer	nce of):						
8760,	cate be executed physicien and the burial-transit	dlcai		d							
	artifica ing ph e as th		IF FEMALE:								
Вох	eath certifi attending for use as	ian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnanc 1 ☐ Live birth 2 ☐ Fetal de	eath 3 🗌	Ectopic pregnancy			23d. Date of del Month	Day Year	
P.O.	that the death cer ed by the attendin detached for use	ysic	1 □ Yes 2 ☑ No 9 □ Unknown	4 Pregnant at time of deat 9 Unknown	n 5∐	Other (specify)					
ם.	that the hold by detac	by Physician/Me	Part II. Other significant conditions con		ng in the un	derlying cause give	en in Part I.	23e. Did toba	the cause of death?		
rds,	quires n sign	q p	Hypertension, Dy	sphagia				1 ☐ Yes	2 No 3 Pr	obably 420Unknown	
000	w requir been si should	et							045 144	topsy findings available	
æ i	10 to 10	ם						24a. Was an	24b. Were at	completion of course of	
_ (	The lay	omo		<u> </u>				autopsy performe	prior to death?	completion of cause of	
ital	ilsn: The lav ertificete has ctor, page 2	Be Completed	25. Was case referred to medical				26. Place of Death	autopsy performe	prior to death?	completion of cause of	
of Vital	hysicism: The lav his certificete has il director, page 2	Be	examiner? 1 ☐ Yes 2 ☐ No		VOutpatient	3□ DOA Othe	or: 4X Nursing Hor	autopsy performe 1 Yes 25 (Check only one)	prior to death?	completion of cause of 2 ☐ No	
n of Vital	ing Physicism: The lav Mer this certificete has uneral director, page 2	To Be	examiner? 1 ☐ Yes 2 ☐ No  27. Manner of Death 1 ☐ Natural 5 ☐ Pending	1   Inpatient 2   EF	VOutpatient Bb. Time of Injury	28c. Injury Work	AX Nursing Hor	autopsy performe 1 Yes 25 (Check only one)	prior to death? No 1 Yes	completion of cause of 2 ☐ No	
sion of Vital	Itending Physicism: The lavideath. Jeath. Itor: After this certificete has the funeral director, page 2	To Be	examiner? 1	28a. Date of Injury (Month, Day Year)	Bb. Time of Injury	28c. Injury Work M 1 []	or: 48 Nursing Hor vat √? Yes 2 □ No	autopsy performe 1 Tyes 26 (Check only one) ne 5 Residen 28d. Describe how	d?   prior to death?   1   Yes	completion of cause of 2 ☐ No	
É	ysicien: The la is certificete has director, page 2	To Be	examiner? 1	1 Unpatient 2 UEF	Bb. Time of Injury	28c. Injury Work M 1 []	or: 48 Nursing Hor vat √? Yes 2 □ No	autopsy performe 1 Tyes 25 (Check only one) ne 5 Residen 28d. Describe how	d? death? No 1 Yes  ce 6 Other (Special injury occurred	completion of cause of 2 ☐ No	
<u>ה</u>	Hospital or 4 hours efte Funers! Din ety filled in I	Certification: To Be	examiner?  1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending investigation  3 Suicide 4 Homicide 6 Could not be determined	28a. Date of Injury (Month, Day Year)  28e. Place of Injury · At hombuilding, etc. (Specify)  sician: To the best of my knowle	Bb. Time of Injury e, larm, stre	28c. Injury Work M 1 1 3	PC: 4X Nursing Hor rat ?? Yes 2 \( \subseteq No \)	autopsy performs 1 Tyes 25 Check only one)  me 5 Residen 28d. Describe how 28l. Location (Stre City or Town,	d? dath? 1 Yes  ce 6 Other (Speinjury occurred  et and Number or Rostate)  se(s) and manner as	completion of cause of 2 No Cify)  ural Route Number,	
<u>ה</u>	Hospital or 4 hours efte Funers! Din ety filled in I	To Be	examiner?  1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending investigation  3 Suicide 6 Could not be determined  29a. Certifier 1 Certifying Physical Certifier 1 Certifying Physical Certifier 1 Certifying Physical Certifier 1 Certifying Physical Certifier 1 Certifying Physical Certifier 1 Certifying Physical Certifier 1 Certifying Physical Certifier 1 Certifying Physical Certifier 1 Certifying Physical Certifier 1 Certifying Physical Certifier 1 Certifying Physical Certifier 1 Certifying Physical Certifier 1 Certifying Physical Certifier 1 Certifier	28a. Date of Injury (Month, Day Year)  28e. Place of Injury - At hombuilding, etc. (Specify)	Bb. Time of Injury e, larm, stre	28c. Injury Work M 1 1 3	er: 4% Nursing Hor r at r? Yes 2 \( \text{No}\)	autopsy performs 1 Tyes 2%.  (Check only one) me 5 Resident 28d. Describe how 28l. Location (Stre City or Town, and due to the caued at the time, date	d? dath? 1 Yes  ce 6 Other (Speinjury occurred  et and Number or Rostate)  se(s) and manner as	completion of cause of 2 No  2 No  cify)  ural Route Number,  stated. to the cause(s)	
<u>ה</u>	in Die	edicai Certification: To Be	examiner?  1	28a. Date of Injury (Month, Day Year)  28e. Place of Injury · At hombuilding, etc. (Specify)  sician: To the best of my knowle	Bb. Time of Injury e, larm, stre	28c. Injury Work M 1 1 3 eet, factory, office occurred at the time estigation, in my of	er: 4% Nursing Hor r at r? Yes 2 \( \text{No}\)	autopsy performs 1 Tyes 28 (Check only one) me 5 Thesiden 28d. Describe how 28d. Describe how 28l. Location (Stre City or Town, and due to the caued at the time, date 29d	d? dath? 1 Yes  ce 6 Other (Speciniqury occurred  et and Number or Ro State)  se(s) and manner as and place, and due	completion of cause of  2 No  cify)  ural Route Number,  stated, to the cause(s)  h, Day, Year)	
<u>ה</u>	Hospital or 4 hours efte Funers! Din ety filled in I	edicai Certification: To Be	examiner?  1	28a. Date of Injury (Month, Day Year)  28e. Place of Injury At hombuilding, etc. (Specify)  sician: To the best of my knowle ner: On the basis of examination and manner stated.	Bb. Time of Injury  e, larm, streedge, death in and/or inv  Ga) (Type, 8	28c. Injury Work M 28c. Injury Work 1 1 2 eet, factory, office  occurred at the tim estigation, in my of	Part All Nursing Hor rat (? Yes 2 No	autopsy performs 1 Tyes 25 Check only one)  me 5 The Residen 28d. Describe how 28d. Describe how 28l. Location (Stree City or Town, and due to the caued at the time, date 29d.  S	d? dath? 1 Yes  ce 6 Other (Speingury occurred  et and Number or Residue) se(s) and manner as and place, and due  in Date signed (Monte)  eptember	completion of cause of  2 No  cify)  ural Route Number,  stated, to the cause(s)  h, Day, Year)	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Physician 12:40 AM E. Joseph 9 17 FO /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Salsbury
If Under 1 Year | If Under 24 Hrs.
Hours | Min. Wicomico Coastal Hospice At the 1 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 ☐ M 2 🗓 F Yrs 82 Director 221-14-9646 8-9-1925 Delaware Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10c. City, Town or Location 10d. Inside City Limits 10a State 10h. County "natural", or Items 23a or 28a-f show dical Examiner must be notified at TY☐Yes 2☐No Director DE Sussex De1mar 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 101 East Delaware Ave. 19940 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14 Bace - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 21 No Specify. þ Specify: White 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 <u>Cafeteria</u> Nursing home is marked other 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked other any lijury or other traumatic event, once. 17. Father's Name (First, Middle, Last) Be Helen Reynolds Morris Harvey Niblett 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Karen McGee 12412 Saltbarn Rd. Laurel, De. 19956 (Cousin) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 KBurial 2 Cremation 3 Removal from State Odd Fellows Cemetery 9-20-2007 Laurel, Delaware 4 Donation 5 Dother (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 700 West St. Hamman Planning Plann Hannigan, Short, Disharoon F.H. Laurel, De. 19956 Approximate Interval Between Onset and Death Physician ancreal 1715 disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner requires that the death certificate be executed burial-tra Due to (or as a consequence of): attending physician Physician/Medical the as IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? ō Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) signed by the and be detached f 9□Unknown Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 🗌 Yes 2 Z No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 22→40 24a. Was an cate has b autopsy Yes director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 25 No 1 Inpatient 2 ER/Outpatient 3 DOA P Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of 7 ath 28b. Time of 28d. Describe how injury occurred

P.O. Box 68760, Division or Vital Records, this certificate Physician: funeral

Baltimore, Maryland 21215-0036

To the Hospital or Attending Pr Within 24 hours after death.

To the Funeral Director; After th completely filled in by the funeral Certification: Medical

State Registrar

and manner stated.

1 ☐ Yes 2 ☐ No

Tecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Salusy MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Essall, MM

31. Date filed (Month, Day, Year) SEP 2 200 0

5 ☐ Pending investigation

6 Could not be determined

Natural 2 Accident

3 Suicide

29a. Certifler

4 ☐ Homicide

(Check only

29b. Signature and title of certifier

Registrar's Signature

Injury

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year 3'10PM Kincai Patricia Septenber 17 *300*5 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Bullione Care Corte Balledore chris Hockers Bullice If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number 8. Date of Birth (Month, Day, Year) Days Hours Min 1 □ M 2 🗷 F 228-46-0380 8/17/1939 Virginia Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Maryland 1 XYes 2 ☐ No Baltimore City 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 1014 Iris Ave. 21205 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify. Specify: White 3X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Residence 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Thomas T. Brammer Ella J. Stone 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barnabas J. Brammer - Brother 130 Fox Run Rd., Hanover, PA 17331 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Black Rock Cemetery 9/19/2007 Butler, Maryland 22. Name and Address of Facility Eline Funeral Home, 934 South 21. Signature of Junyral Service Licensee M001490 Main Street Hampstead, Maryland 21074 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) etter Due to (or as a consequence of): Due to (or as a consequence Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Deaplaha Due to (or as a consequence of) with chest ticke 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 Other (specify) 9∏Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an (Oro-out autopsy perform Diapotes 1☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

**Funeral** 

Director

28a-f show

'natural", or items 23a or 28a-f shov dical Examiner must be notified at

traumatic event, the Medical

72 hours after

filed within Hygiene. than

permit. Pages 1 and 2 should be filed to Department of Health and Mental Hygis Important: If item 27 is marked other 1 any Injury or other traumatic event, the

Baltimore, Maryland 21215-0036

Box 68760.

P.O.

Division or Vital Records,

Director

Funeral

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Completed

Be

Examiner Physician/Medical

sician and burial-trans

attending physician for use as the buria death certificate be certificate has been signed by the rector, page 2 should be detached Attending Physician: funeral director I hours after death. uneral Director: Af ō

To the Hospital within 24 hours a To the Funeral I Hospital State Registrar

IF FEMALE: ģ Completed Be 1 ☐ Yes 2 ◯ No Certification: To 27. Manner of Death 2 Accident 3 ☐ Suicide 4 ☐ Homicide

29a. Certifier

23b. Was decedent pregnant

inpatient 2 ER/Outpatient 3 DOA Date of Injury (Month, Day Year)

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

Descritiving Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

M0021

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29b. Signature and title of certifier

5 Pending investigation

6 ☐ Could not be determined

29c. License number

29d. Date signed (Month, Day, Year) 18,1900)

Bayviewcirele

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5505 190PK 1115 W. S. Green hope him MD 12 a. IT, we Mo è

31. Date filed (Month, SEP Year) 2007 0

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2007 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 16,2007 Sept. Edith May Kiley 1:15A /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** La Plata Civista Medical Center Charles | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Sept. 18, 1933 Birthplace (State or Foreign Country)
 New York 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🛛 F 73 Director 076-26-5761 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2**/**☐ No Directo Waldorf Maryland Charles 10e. Street and Number 10g. Citizen of What Country? 2340 Ironwood Drive 20601 USA 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 Never Married 2 Married White 1 ☐ Yes 2 X No Specify: Specify: 3 XWidowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Security Officer Magazine 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Susan (unavailable) Frank Eickler 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2340 Ironwood Dr., Waldorf, MD 20601 Tammy M. Kiley-Brazerol-Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State Trinity Memorial Gdns 9-25-07 Waldorf, MD 20601 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee M01246 3035 Old Washington Road Huntt Funeral Home Waldorf, MD 20601 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. AnoxIC Encephalopatry Immediate Cause (Final disease or condition resulting in death) **Physician** gays /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Due to for as a consequence of cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 🗷 No Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Diabetes mellitus 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown page 2 should arthutis 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an 25. Was case referred to medical examiner?

1 Yes 2 No funeral director, 26. Place of Death (Check only one) Hospital: 1 npatient 2 2
28a. Date of Injury
(Month, Day Year) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 2 ER/Outpatient 3 DOA this 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: Aft completely filled in by the fur 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ravinder K. Sindhwani, 11350 Pembrook Sq. Suite 304 Waldorf, Md. 20603

R. Sindheum

29b. Signature and title of certifier\_

31. Date filed (Month, Day, Year) SEP 2 4 Colum

Registrar

29c. License number

D-61614

29d. Date signed (Month, Day, Year)

Seftember 16,2007

		1 - For State Registrar		of Marylan	d / Depa <i>Cer</i>	artmer <i>tificat</i>	t of Heal e of Dea	th and Math	R	eg. No.	007	32073
Physic	ian	Decedent's Name (First, Middle							2. Date of Dear Month	Day	Year	3. Time of Death
/Med	ical	JAN 4a. Facility Name (If not institutio	ICE D.			4b City	Town, or Loca	ation of Dogth	SEPT.	19,	2007 ounty of Death	1:30 P M
Exami	ner	MANOR CARE		· ·		City.	WHEAT(				ONTGOM	
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Unde Months	1 Year If U	Inder 24 Hrs. ours Min.	8. Date of Birth (Month, Day)			nplace (State or Foreign untry)
Director	6	409-30-4425	1 ☐ M 2( <b>X</b> F	81	Yrs.	MOTITIS	Days no	JUIS WIII.	NOV. 27	7,192	5 TE	NNESSEE
and		Usual Residence of Decedent  10a. State 10b. County		10c. Cit	y, Town or Lo	cation						10d. Inside City Limits
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I Z IZ IS-UOSO filed within 72 hours after Hygiene. ther than "natural", or Ite out, It's Medical Examina	by Fu	1 Never Married 2 Mar	. If Yes, C			1 🗆 Yes	2 <b>X</b> I No Sp	ecity:		Sp	ecify:	
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in 72	piet	(Specify only highe	est grade completed		(Give	kind of w	ork done during ise retired)	most of work	ring	TOD. INITIO	01 0001110000	dustry
d with	Completed	Elementary/Secondary (0-12)	College	(1-4or 5+)		HOME	MAKER				HOME	
al Hyg	Be	17. Father's Name (First, Middle,	Last)				18.	Mother's Nam	e (First, Middle,	Maiden Su	imame)	
Menta Menta arked	2	OSCAR	В.	DEAN				GR	ACE	E	DGEN	
2 short and 1 short shor	1	19a. Informant's Name/Relation				•	•		al Route Number			(ip Code)
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DESILITIOTE, INICITY CALLE 13-0030 permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28s-1 show any injury or other traumatic event. Its Medical Examinations must be notified at once.	1	1 ☐ Burial 2X Cremation		n State	cemetery, crer	natory or	other place)	1				
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is, r.C. box of the first the death certification of the ettending for the defact of the death o	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ▼ No 9 □ Unknown	1 Live	outcome of pregna birth 2 TFeta gnant at time of conown	al death 3	Ectopic p	pregnancy pecify)			236	d. Date of deli Month	ivery Day Year
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SION tending leath. tor: After the fune	ation:	1 X Natural 5 ☐ Pend		onth, Day Year)	Injury	м	28c. Injury at Work?	2 🗆 No	200. 20001130 11	o	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
DIVISION  To the Hospital or Attending I within 24 hours after death.  To the Funeral Director: After completely filled in by the funer	Certifica	3 Suicide 6 Could	not be 28e. Pla	ce of Injury - At h Iding, etc. (Speci	lome, farm, sti fy)	reet, facto	ry, office		28f. Location (S City or Tow	itreet and I m, State)	Number or Ru	ural Route Number,
he Hospl in 24 hour he Funer pletely filli	edical	29a. Certifier 1 XCertify (Check only one) 1 Medica	ing Physician: To t Il Examiner: On the and ma	he best of my kno basis of examina anner stated.	owledge, deat ation and/or in	h occurre vestigatio	d at the time, d n, in my opinio	ate and place, n, death occur	and due to the c rred at the time, c	ause(s) ar date and p	nd manner as lace, and due	s stated. to the cause(s)
To the I within 2 To the I complet	×	29b. Signature and title of certifi	n na 7	)		29	c. License nur	mber		29d. Date	signed (Monti	h, Day, Year)
3		· XI		<			D58962	2		SEPT	. 19,	2007
		30. Name and address of person					OT 1		m 100	A	3.00	20022
		SHASHANK G.  31. Date filed (Month, Day, Yea.	r) 32	Registrar's Sign	ature			s. SUIT	E 103, (	JLNEY	, MD.	20832
Regis	tate trar	SEP 21	2007	rogistral o oigh	K Son	ant s	-					

For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1 Decedent's Name (First, Middle, Last) Day Year Month 6:25 a M **Physician** September 19 2007 Jung Hee Lee /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Randolph Hills Nursing Center Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 1 M 2 F Yrs. 89 November 22,1917 Korea Director 136-94-5289 Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County worte ! 27 is marked other than "natural", or items 23s or 28s-f ebov traumatic event, the Mudical Examinar must be notified at 1 ☐ Yes 2 🖾 No Director Rockville Maryland Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20853 Korea 14102 Canterbury Lane Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. e filed within 72 hours after all Hygiene. I Hygiene. I other than "natural", or Itel 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖺 No Specify: à 3 Widowed 4 ☐ Divorced Asian Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Private 6 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be OK Keun Seo 2 Chan Sup Lee Pages 1 and 2 should 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Kyungsoo Choi - Son 14102 Canterbury Lane, Rockville, Maryland 20853 other 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 5 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If eny injury or 4 Donation 5 Other (Specify) 9/21/2007 Olney, Maryland Norbeck Memorial Park 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 11800 New Hampshire Avenue, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Septic Shock /Medical Due to (or as a consequence of): **Examiner** Urinary Tract Infection Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner ettending physicien and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☒ No 4 ☐ Pregnant at time of death 5 Other (specify) signed by the e 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Diabetes Mellitus Type 2 Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Alzheimer's Disease certificete hes lirector, page 2 s autopsy performed? 2 No 1 Yes To the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 🖾 Nursing Home 5 🗆 Residence 6 🗀 Other (Specify) 2 ER/Outpatient 3 DOA ၉ 1 Yes 2 No Director: After this d in by the funeral of 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 27. Manner of Death 28c. Injury at Work? Certification: 1 Natural 5 Pending investigation 1 Tes 2 No death. 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a

To the Funeral Completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier September 19, 2007 D52261 ar death (Item 23a) (Type, Print) 30. Name and address of person who completed cause of Alan Richard Segal, M.D., 1517 Hugo Circle, Silver Spring, Maryland 20906 31. Date filed (Month, Day, SEP 32 State 2007 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month **Physician** Raymond Lantos September 15, 2007 05:55 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Bethesda Health & Rehabilitation Ctr. Bethesda Montgomery If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours Director 193-18-0949 Oct. 13, 1924 Pennsylvania Usual Residence of Decedent 10c. City, Town or Location r 28a-f show notified at 10a. State 10d. Inside City Limits 10b. County 1X Yes 2 No Director Maryland Montgomery Rockville 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number items 23a or 2 Iner must be n permit. Pages 1 and 2 should be filed within 72 hours after death w Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a any lipiury or other traumatic event, the Medical Examinar mores. 5801 Nicholson Lane, # 431 20815 U. S. A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 X Yes 2 No Army If Yes, Give Year or Dates: WW 2 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White 2 3 Widowed 4 Divorced WW 2 Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 5+ Physician Medical 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Joseph Lantos Theresa Freud 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Marjorie M. Lantos - Wife 5801 Nicholson Lane, # 431, Rockville, Md. 20852 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 X Removal from State Arlington Nat'1 4 ☐ Donation 5 ☐ Other (Specify) 9/26/2007 Arlington, Virginia 21. Signature of Funeral Service License Danzansky-Goldberg Memorial Chapels, Inc. 1170 Rockville Pike, Rockville, Maryland 23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each lin death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Weeks Immediate Cause (Final disease or condition resulting in death) Infected Sacral Decubitis **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, france in a line of the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Parkinsons Disease Years Due to for as a consequence of Examine executed Years Dementia and as the burial-trar Due to (or as a consequence of): Box 68760. attending physician requires that the death certificate be Physician/Medical IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a P.0. 1 ☐ Yes 2 ☐ No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records. þ Hypertension, Hypokalemis, Pneumonia 1 Yes 2 No 3 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy 27 No funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 412 Nursing Home 5 | Residence 6 | Other (Specify) 1 ☐ Yes 2X No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မှ After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 ☐ Pending investigation Injury To the Hospital or Attendin, within 24 hours after death.

To the Funeral Director; Aft completely filled in by the fun 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) DO057630 09-17-2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Anuradha Arun 10301 Georgia Avenue, Suite 209, Silver Spring, Md. 20902 Dr. egistrar's Signature

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

SEP

2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygier 1 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Edward Joseph Long, Jr. September 18, 2007 9:00 p M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** St. Catherine's Nursing Center Emmitsburg Frederick If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1**⊠**M 2□F 218-26-2862 76 Director Jan 15, 1931 Maryland Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits Director Maryland Frederick Emmitsburg 1 XYes 2 □ No 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 1 Irishtown Road 21727 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: 1 ☐ Yes 2X No Specify: Specify: white þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Maintenance Supervisor Bakery 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Edward J. Long, Sr. Hilda V. Pattison 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary P. Long, wife 1 Irishtown Road, Emmitsburg, MD 21727 20b. Place of Disposition (Name of cometery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 9/22/2007 ' 4 □Donation 5 □ Other (Specify) New St. Joseph's Emmitsburg, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Myers-Durboraw Funeral Home 210 W. Main Street, Emmitsburg, MD 21727 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** YUUMONA124 /Medical Due to (or as a consequence of) Examiner 0-3 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine attending physician and for use as the burial-transit IVE fulmant The law requires that the death certificate be executed HIZONI that initiated events resulting in death) Last Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) i signed by the a ld be detached for 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ been sig 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has lirector, page 2 performed 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: ၉ 1 ☐ Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) : After this funeral 27 Manner of Death 28a. Date of Injury (Month, Day Year) Natural 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending death. investigation 1 ☐ Yes 2 ☐ No Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funerel ( Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medicai and manner stated 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Souila Date filed (Month, Day, Year)

State Registrar

ype or Print in Black indelible ink. Ensure All Copies Are Legible.	
State of Maryland / Department of Health and Mental Hygiene 2007	32077

	اس	For State amend #5 Pe					2. Date of Death			3. Time of De	ath
nysici	_	Randall Le Flo	ore, Jr				Septembe		Year 2007	6:44	$\mathbf{P}^{M}$
'Medic xamin		4a. Facility Name (If not institution, give s			4b. City, Town, or	Location of Death		4c. County of	Death		
Aditiiti		St. Agnes Hospital			Baltim	ore		N/A			
neral ector		5. Social Security Number 8484 556 66 2484 15	7. Age (In yrs. la 63	a <i>st birthday)</i> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 4/27/194	Year) 4	9. Birthpla Countr Texa	ace (State or F y) S	oreigi
7		Usual Residence of Decedent  10a. State 10b. County	10c. City	, Town or Lo	cation				10	d. Inside City	Limits
event, the Medical Examinar must be notified at	ţ	CA Yolo	Day	71 C						1 🗌 Yes 2	No
Total Control	Director	10e. Street and Number	Dav	10	10f. Zip Code		10	g. Citizen of W	hat Count	ry?	
4	O E	2707 Blackburn Di	·		95616			USA			
	Funeral		12. Was Decedent Ever in U. Armed Forces?	S. 13.	Was Decedent of Hi If Yes, specify Cuba	spanic Origin? (Span, Mexican, Puerto	ecify Yes or No- Rican, etc.)		- America		
A STATE OF THE STA	þ	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☑ Divorced	1 ☐ Yes 2 ☐No If Yes, Give Year or Dates:		1□Yes 2¶No	Specify:		Specify:	Whit		
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natic	၉	Randall Le Flo		10h Mailir	ng Address (Street				State. Zip (	Code)	
othar treumatic		Lewis C. Le Flore			Blackbur		vis, CA	-			
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ian		shock, or heart failure. List only or Immediate Cause (Final	Pseudomyxo	oma Pe	ritonei					Onset and De	ath
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	by Physici	Part II. Other significant conditions co	ntributing to death but not res	ulting in the u	ınderlying cause gıv	en in Part I.	23e. Did tob	acco use contr	bute to th	e cause of dea	ath?
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5	T.in	27. Manner of Death 1 SNatural 5 Pending	28a. Date of Injury (Month, Day Year)	28b. Time o	of 28c. Injur Wor	y at k?	28d. Describe ho	w injury occurr	ed		
	atic	2 Accident investigation			M 1 🗆	Yes 2 □ No					
	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At he building, etc. (Specif	ome, farm, st y)	reet, factory, office		28f. Location (St. City or Town		er or Rura	l Route Numbi	∋ <i>r</i> ,
	Medical C	29a. Certifier 1 (X Certifying Phy one) 1 (X Certifying Phy 2 ☐ Medical Exam	sician: To the best of my knowner: On the basis of examina and manner stated.	owledge, deal ation and/or in	th occurred at the time	ne, date and place pinion, death occur	and due to the carred at the time, da	use(s) and ma ate and place, a	nner as st and due to	ated. the cause(s)	
ed in	Mec	29b. Signature and title of lertifler	and marrier states.		29c. Licens	e number	2:	9d. Date signed	(Month, I	Day, Year)	
not		> \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	Am.		ASZ43	5283697	S	ept. 21	, 200	07	
3		-IM I WIM	V 11FD							·	
7		30 Name and address of person who o	ompleted cause of death (Iter	n 23a) (Type	. Print)						
complet		30. Name and address of person who of Jill Halonen	ompleted cause of death (Iter		.Print)	MD 21229					

7-07488 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Daniel Roy Lewis State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No. Registrar 2. Date of Death Decedent's Name (First, Middle,Last) Physician/ Month Day Year September 24, 2007 Medical Examiner Daniel Roy Lewis 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 10405 Bethesda Church Road Damascus Montgomery If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Months Days Min Director Country) 1 X M 2 F Yrs 217-19-3143 39 1968 Usual Residence of Decedent 10c. City, Town or Location 10b. County 28a-f show notified at once Maryland Frederick Frederick death with the Maryland Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 7185 F Cypress Court 238 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 11. Marital Status 12. Was Decedent Ever in U.S þ 1 Never Married 2 X Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Yes Yes, Give Year Yes 2 X No specify: Specify: White Widowed 4 Divorced þ 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed Elementary/Secondary (0-12) College (1-4 or 5+) Pages 1 and 2 should be filed within 72 21215-0036 10 contractor/construction ont of Health and Mental Hygiene.
nt: If item 27 is marked other the self employed 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be umatic event, Benjamin Roy Lewis Dorothy Ann Sonifrank 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cog Wheel Way, Germantown, Maryland Benjamin Lewis, father 10/1/2007 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State timore, 1 X Burial 2 Cremation 3 Removal from State crematory or other place) tant: Department Clarksburg Methodist Cem. Other Specify: Donation 5 Stonature of Funeral Service Licensee I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart e. List only one cause on each line. Part I. Enter the disease. Physician /Medical a Subarchnoid hemorrhage Immediate Cause (Final disease taminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be executed and Physician/Medical UNPENDED X AMENDED, 27,28a-f, perME, g873, 11/16/07 TT Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Live birth Ectopic pregnancy Fetal death past 12 months Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Completed 24a. Was an autopsy performed? Yes 2 No the Hospital or Attending Physician: 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Other<sub>4</sub> Hospital: 4 DOA Nursing Home 5 Inpatient 2 ER/Outpatient 1 Yes 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death Certification: Natural Yes 2 X No Pending unk Fnd 9/24/2007 Fnd 3:00 pm 2 Investigation Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. 6 X Could not be 3 Suicide

Clarksburg, Maryland 22. Name and Address of Facility Molesworth-Williams Funeral Home 20872 26401 Ridge Road, Damascus, Maryland Approximate Interval Between Onset and Death 23d. Date of delivery Year 23e. Did tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 V Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 V Yes 2 No Residence 6 V Other: Scene 28f. Location (Street and Number or Rural Route Number, City or Jown, State) 10405 Bethesda Church Rd Damascus, MD (Specify) found in truck Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. September 25, 2007 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Registrar's Signature ORIGINAL

Registrar

and manner stated

2007 32078 1510 hrs

Maryland

10d. Inside City Limits

Yes 2 X No

To the Funeral

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State

one)

Homicide 29a. Certifier 1

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Patricia Aronica-Pollak MD

DHMH 17 Rev 1/2001 OCME 2006

			For State Registrar	State of	Maryland			of Health ar of Death	nd Men		ien	007	32079
	Physici /Medic		1. Decedent's Name (First, Middle, Las Fred Tobius	1	naer				1	Date of Deat Month O	th Pay	Year 200	3. Time of Death
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H	Funeral Director		5. Social Security Number 6. S		Age (In yrs. las	t birthday) Yrs.	If Under 1 Months E		Min. 8. r	Date of Birth Month, Day 0/09/	1918	9. Birt Co	hplace (State or Foreign buntry) PA
	ehow	٥٢	Usual Residence of Decedent  10a. State 10b. County  Maryland Frederic	<	-	Town or Lo							10d. Inside City Limits 1 ☐ Yes 2 ☐ Yes
	with the N 3s or 28s-f 1 be notified	Funeral Director	10e. Street and Number 3200 BAKER Circle				10f. Zip Co	ode 710			0g. Citize	n of What Co	
036	2 should be filed within 72 hours after deeth with the Maryland and Mental Hygiene. I and Mental Hygiene is marked other than "natural," or items 23s or 28s-f ehow aumatic event, the Madical Examinar must be notified at	þ	11. Marital Status  1 Never Married 2 Married  3 Note: Married 4 Divorced	12. Was Decede Armed Force 1 XYes 2 If Yes, Give Year or Date	s? □ No	'	Was Decedent f Yes, specify	it of Hispanic Origin Cuban, Mexican, F	n? (Specify Puerto Rica	Yes or No- n, etc.)		Race - Ame Black, Whit pecify: Whi	e, etc.
Baltimore, Maryland 21215-0036	d within 72 hor giene. In then "natura The Medical E	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)	ducation (de completed)  College (1-4)	or 5+)	(Give	DO NOT use :	don <i>e during</i> most o	of working		16b. Kind	of Business	
/land	wild be filed Mental Hyg arked other atic event,	To Be C	17. Father's Name (First, Middle, Last, Fred F. Lininger			С		18. Mother's Mildr	s Name (Fir red To		Maiden S	итате)	
, Mar.	and 2 sho selth and I n 27 ie mu er trauma		19a. Informant's Name/Relationship ( Fred kirkpatrick			1100	Jonuu	il Circle					
more	permit. Pages 1 and 2 should be Department of Heelth and Menta important: If item 27 is marked eny injury or other traumatic ex QDGE.		20a. Method of Disposition  1 ☐ Burial 2 ☐ €remation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif		cen	ce of Dispo netery, cren	sition (Name natory or othe	of :	Date	2007	20c. Loca	tion - City or	Town, State
Balt	permit. Deperti import. eny inj		21. Signatur of Funeral Service Licer	1500		22	Name and A	Address of Facility (	Colon: y Rd 1	ial Fu Leesbu	inera itg,	l Home VA 201	.76
<b>)</b>	Physician		23a. Part1. Enter the sease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	plications that cau one cause on eac	sed the death. h line. h line.	Do not ent	er the mode o	of dying, such as ca	ardiac or res	spiratory arr	est,		Approximate Interval Between Onset and Death
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68760,	tificate be ng physici as the bu	fedicai		_ d									
O. Box	the death certificat by the attending phy sched for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		n 2 ∏ Fetal d t at time of dea	eath 3	Ectopic preg Other <i>(spec</i>				23	d. Date of de Month	livery Day Year
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Division of Vital Records,	: The law recete has be	Completed							_	24a. Was a autops perform	sy med?	prior to death?	utopsy findings available completion of cause of
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N N	itel or Attencurs efter deatt rai Director: lled in by the		4 Homicide determined	building	Injury - At hom , etc. (Specify)					City or Tow	n, State)		ural Route Number,
	To the Hospitel or A within 24 hours effer To the Funeral Direction Completely filled in by	fedical	(Check only 2   Medical Example)	nysician: To the basi niner: On the basi and manne	s of examinatio	ladge, detall on and/or in	vestigation, in	the time, date and my opinion, death	place, and occurred a	t the time, d	late and p	lace, and du	e to the cause(s)
)	To To	Σ	29b. Signature and title of certifier		mo			oc 5872	G	2		signed (Mon	th, Day, Year)
			30. Name and address of person who 3000-i) Vent	d1	of death (Item 2 MY 2851	Me 1	WO 217	73					
(1)	Sta Registi		31. Date filed (Month, Day, Year)  OCT 0 5 200		istrar's Signatu	Span	E)						
DLU	4H 17 Pay 1/2	001											

DHMH 17 Rev 1/2001

Box 68760, Division or Vital Records, P.O.

attending physician and for use as the burial-transit signed by the a d be detached f certificate has been si rector, page 2 should funeral director, al or Attending P neral Director: A To the Hospital within 24 hours at

**Physician** 

/Medical

Examiner

Director

Funeral

þ

Completed

Be

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any livry or or other traumatic event, the Medical Examiner must be notified at

altimore, Maryland 21215-0036

Physician disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Unerlying Cause (Disease or injury that initiated events Examiner resulting in death) Last Physician/Medical IF FEMALE 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ★No 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Completed 25. Was case referred to medical examiner? Be 1 ☐ Yes ို Manner of Death Certification: 1 Atural 2 Accident 3 Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours af

To the Funeral D

completely filled i 29a. Certifier Esertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifie

29d. Date signed (Month, Day, Year)

Name and address of person who completed cause of death (Item 23a) (Type, Print)

M

31. Date filed (Month, Day, Year)

State Registrar

			State of Maryland		artment of rtificate o		ind Mental	Hygien Reg. N		32081
E	Dhuniai	(2)	Registrar  1. Decedent's Name (First, Middle, Last)				2. Date	of Death	av Year	3. Time of Death
1	Physicia /Medic	al	Gertrude  4a. Facility Name (If not institution, give street and number)		Marcus	s, or Location of	09/20	)/2007	7 Ic. County of Deat	5:30 A M
	Examin	er	SUNRISE ASSISTED LIVING		ROCKVII	LLE			ONTGOME	RY
	Funeral Director		5. Social Security Number 063−14−2406 6. Sex 1 M 2 ★ 7. Age (In yrs. It		If Under 1 Ye Months Day			of Birth h, Pay Yea 0/1913	9. Birt Co GEI	hplace (State or Foreign untry) XMANY
	land ow		Usual Residence of Decedent           10a. State         10b. County         10c. City	, Town or Lo	ocation					10d. Inside City Limits
	ne Many 8a-f sh ptified	Director		KVILLE				100		1X Yes 2 No
	3a or 2		10e. Street and Number  8 BALTIMORE ROAD		10f. Zip Code	20850		10g. C	Offizen of What Co USA	ountry ?
36	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hyglene. Item 27 Is marked other than "natural", or items 23a or 23a-f show other traumatic event, the Medical Examiner must be notified at	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 ☒ Widowed 4 □ Divorced  12. Was Decedent Ever in U.S Armed Forces?  1 □ Yes 2 ☒ No If Yes, Give Year or Dates:		Was Decedent of If Yes, specify C		gin? (Specify Yes , Puerto Rican, etc	or No-	14. Race - Ame Black, Whit Specify: WH	
Baltimore, Maryland 21215-0036	within 72 hou ene. than "natura ne Medical E	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  12  College (1-4or 5+)	16a. Dece (Give life.	dent's Usual Oci kind of work do DO NOT use ret	cupation ne during most ired)	of working		Kind of Business/	
nd 2	al Hygid I other vent, tl	Be Co	17. Father's Name (First, Middle, Last)			-	r's Name (First, M	iddle, Maide		
<u>⊠</u>	should be and Mental Is marked or aumatic eve	2	WILHELM LILIE  19a. Informant's Name/Relationship (Type. Print)	19b. Maili	na Address (Stre	1	IE FRIEDN		y or Town, State, 2	Zip Code)
, Ma	and 2 s ealth ar n 27 Is ier trau		EVELYN MARCUS-WHEELER - DAUGHTE	R 8603	3 WILD	OLIVE I	ORIVE, PO	TOMAC	, MARYLA	ND 20854
timore	Page nent o ant: If ury or		4 □ Donation 5 □ Other (Specify)  LAK	ESIDE	osition (Name of matory or other) MEML PA	RK 09	Date 9/23/2007	MIA	Location - City or	RIDA
Ba	permit. Departr Imports any Inj		21. Signature of Funeral Service Licensee	i i	EDWARD S 1091 ROC	AGEL FU KVILLE	NERAL DI PIKE, RO	RECTI	ON, INC. LE, MARY	LAND 20852
	Physician		23a. Part T. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line.  Immediate Cause (Final SEVERE DEME		ter the mode of o	dying, such as	cardiac or respirat	ory arrest,		Approximate Interval Between Onset and Death YEARS
4	/Medical		disease or condition resulting in death)  a. Due to (or as a consequence)							
	Examiner	e.	Sequentially list conditions, if any, leading to immediate the control of the con	uence of):						
	ecuted and transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last  C	iongo of):						
8760,	cate be executed oblysician and the burial-transit	dical E	d	ence on.						
Box 6	The law requires that the death certifica to has been signed by the attending phoage 2 should be detached for use as the	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown  23c. If yes, outcome pf pregnant 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of do 9 □ Unknown	death 3[	⊒Ectopic pregna ⊒Other (specify				23d. Date of de Month	livery Day Year
ds, P.O	w requires that is been signed by should be detail	by	Part II. Other significant conditions contributing to death but not resu	Iting in the u	ınderlying cause	given in Part I.	23e.		**	o the cause of death?
Vital Records,	he law requ e has been ige 2 should	Completed						Was an autopsy performed	24b. Were a	utopsy findings available completion of cause of
Ita		Be Co	25. Was case referred to medical examiner?			26. Place	of Death (Check	oniv one)		3 2 No
or V	Physic or this co	၉	1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatient 2 ☐ 27. Manner of Death 28a. Date of Injury	28b. Time o	III SLI DOA	Other: 4 Nu njury at Nork?	rsing Home 5 28d. Des	Residence	6 XOther (Spenjury occurred	ecify) LIVINGED
Division or	Attending Physician: r death. ector: After this certifics by the funeral director, p	cation	1 X Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	Injury	M 1	I∏Yes 2∏I				
	e i ii ii ii	Certification:	3 Suicide 6 Could not be 4 Homicide determined 28e. Place of injury - At hobiding, etc. (Specify	me, farm, st	reet, factory, offi	ce	28f. Loca City	tion (Street or Town, St	and Number or R afe)	ural Route Number,
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical C	29a. Certifier (Check only one) (Check o							
<b>)</b>		Me	29b. Signature and title of certifier  Shama R- Mutta	0 m	/ 3/	ense number 00061382	2		Date signed (Mon PTEMBER 2	
	3		30. Name and address of person who completed cause of death (Item DR. SHAMA R. MITTAL, 14816 PHYS	ICIANS	S LANE,	SUITE :	152, ROCI	VILLE	E, MARYLA	AND 20850
	Sta Registi		31. Date filed (Month, Day, Year)  SEP 2 1 2007  32. Pgistrar's Signa	b. A	parti					

DHMH 17 Rev 1/2001

			For State Registrar	State of M	laryland / Depa <i>Ce</i>	artment of F rtificate of a			iene eg. No.2 0 0	17	32082
	Dhypici		1. Decedent's Name (First, Middle, Las	st)				2. Date of Deat		Year	3. Time of Death
	Physici /Medic		Randy	Malry				Sept.		007	2115 <sup>M</sup>
	Examir		4a. Facility Name (If not institution, give			4b. City, Town, o	r Location of Death		4c. County o	f Death	
	1	4	Shady Grove Adve			Rockv			Monte		
	Funeral		5. Social Security Number 6. S	Sex 7. A. ■ M 2 □ F	ge (In yrs. last birthday)	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year)	<ol> <li>Birthplace</li> <li>Country</li> </ol>	ce (State or Foreign
	Director		578-70-0652 Usual Residence of Decedent		55 Yrs.			Feb. 2,	1952	South	Carolina
	land ow		10a. State 10b. County		10c. City, Town or Lo	ocation				100	I. Inside City Limits
	Mary f sh	ō	MD Montgom	erv	Commo	ntown					1 Yes 2 No
	r 28a	irec	10e. Street and Number	Cly	у сетша	10f. Zip Code		1	0g. Citizen of Wi	hat Country	ſ?
	3a ol	Funeral Director	18243 Swiss Circ	10 #2		2087	4		U.S		
	death ms 2	ner	11. Marital Status	12. Was Decedent	Ever in U.S. 13.		lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No-	14. Race	- American	
38	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	by Fu	1 ☐ Never Married 2 🛣 Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:	No	1 ☐ Yes 21XI No	Specify:	Hican, etc.)		, White, etc Blac	
21215-0036	72 hou natura dical E	Completed by	15. Decedent's Ed (Specify only highest gra	ducation ade completed)	16a. Dece	dent's Usual Occup	ation during most of work	rina ı	16b. Kind of Bus	iness/Indu	stry
12	vithin ene. than "	mple	Elementary/Secondary (0-12)	College (1-4or	5+)		during most of work d)	9	D-1-1- /	m 1	
	filed Hygid	ပို	17. Father's Name (First, Middle, Last)	<b>)</b>	iruc	k Driver	18. Mother's Nam	e (First, Middle, N	Bob's		ıng
Maryland	ld be ental <b>ked o</b>	To Be	Ernest Malry					ey Tinsl		,	
3	shoul Mind Mind Mind Mind Mind Mind Mind Mind	F	19a. Informant's Name/Relationship (	Type. Print)	19b. Maili	ng Address (Street	and Number or Rui			State, Zip C	ode)
	nd 2 alth a 27 is r trai		Jason Malry / S	on	18243	Swiss Ci	irc1e_#2_	Cermanto	TVD MD	2087/	
re,	s 1 and 2 soft Health are item 27 is		20a. Method of Disposition		20b. Place of Dispo				20c. Location - C		
E	Page nent c nt: If		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specifi		Parklawn	Memorial	Sep.	29, 2007	Róckv	ri 11a	MD
Baltimore,	permit. Departn Importa any Inju		21. Signature of Fuperal Service Licer	isee	) 2	2. Name and Addre	ss of Facility Mo	Guire F	uneral S	ervi	ce, Inc.
<u> </u>	e a E e e		Indre (	I hours.	20m 7.	400 Georg	ia Ave.,	N.W. Was	shington	, D.C	20012
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that cause one cause on each	ed the death. Do not entline.	ter the mode of dyir	ng, such as cardiac	or respiratory arre	est,	11	Approximate nterval Between
Ġ.	Physician		Immediate Cause (Final disease or condition	_a. Sepsis	1						Onset and Death
	/Medical		resulting in death)		s a consequence of):						
9	Examiner	ا ـ ا	Sequentially list conditions,		Valve End	ocarditis					
	ed sit	ije	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		s a consequence of):	1.					
	icate be executed physician and the burial-transit	dical Examiner	that initiated events resulting in death) Last	U	ranial Ble	eding					
68760,	be e sician buria	<u>8</u>		,	, ,					İ	
687	ficate phys	edic		►d							
	Physician: The law requires that the death certificate has been signed by the attending rall director, page 2 should be detached for use as	Ž	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome					23d. Date	of delivery	
Records, P.O. Box	death e atte d for	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant a		∃Ectopic pregnancy ∃ Other <i>(specify)</i>	<i>y</i>		Mon		ay Year
O	t the by the arche	hys	9 Unknown	9∐Unknown							
Š,	s tha gned e det	by P	Part II. Other significant conditions of	=	but not resulting in the u	nderlying cause giv	en in Part I.	23e. Did tob	oacco use contrib	oute to the	cause of death?
ğ	w require s been sig should b	ed k	End Stage Renal	L Disease				1 □ Ye	es 2∑No 3	3 🗌 Probat	oly 4 □Unknown
ပ္ပင္ပ	law re as be 2 sho	Completed						24a. Was a			y findings available
Ě	The ate his	mo;						autops perforr 1□ Yes 2	ned? de	eath?	oletion of cause of ☐ No
ita	ian: ertifica ctor, I	BeC	25. Was case referred to medical examiner?				26. Place of Deal	h (Check only on			
<u>-</u>	hysic nis ce I dire	To	1 ☐ Yes 2 ☑ No	Hospital: 1   Inpat	ient 2 ☐ ER/Outpatier	nt 3 DOA Oth	er: 4 🗆 Nursing Ho	ome 5 Reside	ence 6 Dothe	r (Specify)	
0	ng ffe		27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of Inj (Month, Da		f 28c. Injur Wor	yat k?	28d. Describe ho	w injury occurre	d	
sio	Attending r death. ector; After by the fune	cati	2 Accident investigation 3 Suicide 6 Could not be				Yes 2 □ No				_
Division or Vital	or At after d Direct in by	Certification:	4 Homicide determined	Zoe. Place of in	jury - At home, farm, str tc. (Specify)	eet, factory, office		28f. Location (St City or Town	reet and Numbe n, State)	r or Rural F	Route Number,
	spital		29a. Certifier 1 Certifying Ph	vsician: To the bes	t of my knowledge, deat	h occurred at the tir	me, date and place	and due to the c	ause(s) and man	ner as stat	hed.
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical	(Check only 2 Medical Examone)	miner: On the basis and manners	of examination and/or in	vestigation, in my	ppinion, death occu	rred at the time, d	ate and place, a	nd due to t	he cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier		000	29c. Licens	e number	2	9d. Date signed	(Month, Da	ay, Year)
)	3		1 575	SM.	MO	D00	62435	9	Septembe	r 15.	2007
•	1		30. Name and address of person who	completed cause of	death (Item 23a) (Type,				- F TOMOC		
			Sayed Eisayyad	9715 Medi	cal Center	Dr. Rock	ville, MI	20850			
	Sta		31. Date filed (Month, Day, Year)	32 Gegist	trar's Signature	anti)					
	Registr	ar	SEL HT T	JULY BUILD	han he had						

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) September 20, 2007 **Physician** 8:55 P M John Thomas Miley /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Carroll Westminster Dove House If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Feb 11, 5. Social Security Number 9. Birthplace (State or Foreign 6 Sex 7. Age (In yrs. last birthday, **Funeral** Days New York Min. 1 XM 2 ☐ F 57 101-38-1159 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County show r 28a-f show notified at 1 ☐ Yes 2 No Director MD Carrol1 Westminster 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code "natural", or items 23a or dical Examiner must be 21158 USA 440 Palmer Terrace Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No Specify: White Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Medical Elementary/Secondary (0-12) College (1-4or 5+) event, the Construction Concrete Engineer 18. Mother's Name (First, Middle, Maiden Surname) Maryland 17. Father's Name (First, Middle, Last) Be 1 and 2 should be 1 Health and Mental ပ Thomas Jefferson Miley <u>Margaret Ann Berger</u> 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 is any Injury or other trau once. 0 440 Palmer Terrace Westminster, MD 21158 William C. Miley/son Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 09/24/07 Beltsville, MD 21. Signature of Juneral Service Lio Going Home Cremation Service P.O. Box 784 MO1251 Beverly I. Heckrotte, P.A. Clarksville, MD 21029 or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Approximate Interval Between Onset and Death 23a. Part1. Enter the dise shock, or heart failure. Immediate Cause (Final disease or condition resulting in death) Physician MAC /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed nding physician and use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant atten for u 3 Ectopic pregnancy in the past 12 months? Month 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ. 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performe certificate 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 2 No 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA P 6 Other (Specify) 10500CD this 27. Manner of Death 1 Natural 28a. Date of Injury 28b. Time of I Director: Atter to in by the funeral 28d. Describe how injury occurred Certification: To the Hospital or Attending (Month, Day Year) 5 ☐ Pending investigation 1 Yes 2 No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 100 of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Y Stoner 32. Redstrar's Signature State Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Reg. No 2 0 0 7 32084 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 9/17/2007 **Physician** Gertrude Naomi Moreland 0750am M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 5646 Brooks Woods Rd. Lothian Anne Arundel If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Dav. Year) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 21 F 255-60-5890 7/3/1940 Director Maryland Usual Residence of Decedent show 10a. State 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 1 ☐ Yes 21 No MD Director Anne Arundel Lothian 10e. Street and Number 10g. Citizen of What Country? 10f Zin Code ortant; If item 27 is marked other than "natural", or Items 23a or injury or other traumatic event, the Medical Examiner must be i 5646 Brooks Woods Rd. 20711 USA Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. within 72 hours after 1 ☐ Yes 255tNo If Yes, Give Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0036 White 1 ☐ Yes 2CXNo Specify: ģ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Bus Driver Anne Arundel Schools is marked other t 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William Norfolk Bessie Moreland 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2:
Department of Health ar
Important; If item 27 is
any injury or other trau Albert Moreland Husband 5646 Brooks Woods Rd. Lothian, MD 20711 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 9/20/2007 Mt. Zion Lothian, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service lice 22. Name and Address of Facility Hardesty Funeral Home, P.A. 12 Ridgely Ave. Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Due to (or Ja con equence of): non-Hodakin /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enier Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) that the death certificate be executed burial-tran Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the burial Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4□Pregnant at time of death 5 Other (specify) ed by the a 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Disease 2 No 3 Probably 4 □Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy performed?

1 Yes 2 No funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2NO 1 Inpatient 1 ☐ Yes 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t 12Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No dospital or Attendi 1 hours after death. •uneral Director; A ely filled in by the fu 2 Accident 6 ☐ Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a Hospital 29a. Certifier 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely (Check only and manner stated. To the I within 2. 29c. License number 29b. Signature and title of certifier September 18, 2007 D29193 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Braverton St. #201; Edgawater MD 21037 3169 Stephen

State Registrar 2007

		-	For State Registrar	State o	f Marylar	•	rtment o <i>tificate</i>			d Mental		ne №2 ∩	דח	32085
	Discount of		Decedent's Name (First, Middle	e, Last)			_			Monti	of Death	Dav	Year	3. Time of Death
1000	Physicia /Medic		Marie R. Ma							Sept	embe	18,		12:35 p <sup>M</sup>
	Examin	er	4a. Facility Name (If not institutio		-		4b. City, To		cation of D	eath		4c. County	Arun	del
	Funeral		Heritage Harbou 5. Social Security Number	6. Sex	7. Age (In yrs.		If Under 1	ear If	Under 24		of Birth		9. Birthr	place (State or Foreign
ø	Director		160-01-2969	1 □ M <b>XX</b> F	92	Yrs.	Months E	ays F	Hours N	April	1, <b>30,</b> Ye	1915	Penns	sylvania
	and w		Usual Residence of Decedent  10a. State 10b. County		10c. Ci	ty, Town or Lo	cation							10d. Inside City Limits
	Maryla f sho	ō		Arunde1		Ann	apolis							<b>X</b> XYes 2 □ No
	n the	Directo	10e. Street and Number	ni didei			10f. Zip C	ode			10g.	Citizen of	What Cou	ntry?
	23a c ust be		1 St. Mary's St	reet			2140					nited		
36	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If Item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	by Funeral	11. Marital Status  1 ☐ Never Married 2 ☐ Mar  ★★ Widowed 4 ☐ Divorced	ried Armed Fe	ve		Was Deceder If Yes, specify 1 □ Yes X	v	anic Origin Mexican, P Specify:	? (Specify Yes uerto Rican, et	or No- c.)	Bla	ce - Americk, White, fy: Whi	etc.
ပို	72 hou natura iical E	sted	15. Deceder	nt's Education est grade completed)		16a. Dece	dent's Usual (	occupatio	n na most of	workina	16	b. Kind of E	Business/In	dustry
2	vithin ne. han " e Mec	Completed	Elementary/Secondary (0-12)	College (	1-4or 5+)	life.	DO NOT use <b>Ret</b>	retired)		3		Fur	nitur	· <b>e</b>
7 9	filled v Hygie ther t		12 17. Father's Name ( <i>First, Middle</i>	Last)			Net		B. Mother's	Name (First, M	liddle, Mai			
an	fental fental rked c	To Be	John B. Caccamo					1	Mary	DeFrisc	ю.			
lary	she she		19a. Informant's Name/Relation	ship (Type. Print)			•			r Rural Route I				
ტ 	l and lealth im 27 ther tr		Carole Comfort 20a. Method of Disposition	/ Daughte					ane	Manahaw Date	_	New c. Location		y 08050
nor	ages int of h		1 Burial 2 remation		State	Place of Dispo			- 0/	19/2007				Maryland
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any Injury or other tra		4 □ Donation 5 □ Other (		Da		2. Name and							al Home, In
ñ	permi Depar Impor any Ir		Michael [	- Illian		1	47 Duk	e of	G1ou					MD 21401
	W. J.		23a. Part1. Enter the disease, of shock, or heart failure. Lis	r complications that t only one cause on	caused the dea each line.	ath. Do not en	ter the mode	of dying, s	such as ca	rdiac or respira	tory arrest	9		Approximate Interval Between Onset and Death
·	Physician		Immediate Cause (Final disease or condition resulting in death)	a. <u></u>	nd S	tage	De	noi	rtu	ī				my ymy
	/Medical Examiner		resulting in death)	Due to	(or as a conse	quence()of):	+1-		\					3 menty
Ä	έ -ω, (. <sup>1</sup>	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to	(or as a conse	quence of):		IXT	ne					,
	cuted	Examiner	that initiated events	<b>S</b> c										
8760,	cate be executed physician and the burial-transit	I Ex	resulting in death) Last	Due to	(or as a conse	quence of):								
687	icate h	dical		d										
Box (	death certific e attending p ed for use as	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant		atcome pf pregi		75-4					23d. D	ate of deliv	very
	0 0	sicia	in the past 12 months? 1 ☐ Yes 2 🗷 No		birth 2□Fe Inant at time of nown		□Ectopic preg □Other (spec					N	onth	Day Year
P.O.	requires that the de een signed by the a hould be detached f	Phy	9 ☐ Unknown  Part II. Other significant condit			sulting in the u	ınderlying cau	se given i	in Part I.	23e	Did toba	cco use co	ntribute to	the cause of death?
ds,	w requires that s been signed to should be det	d by	, arm other eighneam contain				,	<b>3</b>			1 🗌 Yes	2□ No	3 □ Pro	bably 4 Hunknown
Records,	> 0 0	Completed								24a	. Was an	24b	. Were aut	opsy findings available
	The lav	omp								_	autopsy performe Yes 2	d? No	death?	ompletion of cause of 2 ☐ No
lital		Be C	25. Was case referred to medic examiner?						6. Place of	Death (Check				
or Vital	Physician: r this certific ral director,	은	1 Yes 2 No 27. Manner of Death		Inpatient 2 [	ER/Outpatie		Other:		ing Home 5		ce 6 🗆 O		ify)
	Attending r death. ector: Affer by the funer	tion	1 Natural 5 ☐ Pend	/8.40	nth, Day Year)	Injury	м 25	i. Injury a Work? 1 ∐ Ye	s 2∐No		cribe now	injury cook	anca	
Division	Atten rr deat ector by the	Certification:	3 Suicide 6 □ Could	I not be 28e. Plac	e of injury - At ding, etc. (Spec	home, farm, st	reet, factory,	office		28f. Loca	tion (Stre	et and Nun State)	nber or Ru	ral Route Number,
	ital or rs afte ral Dir led in	Cert	, , , , , , , , , , , , , , , , , , , ,			,								
	To the Hospital or Attending Ph within 24 hours after death.  To the Funeral Director: After th completely filled in by the funeral	edical		ing Physician: To the I Examiner: On the										
	o the vithin 2 or the omple	Med	29b. Signature and title of certif		inici siaieu.			License n		2	290	I. Date sign	ned (Month	n, Day, Year)
	U,	$\zeta_{I}$	1 Danis				T	00	40	51		9/1	2/0	7
	300	X	30. Name and address of perso	n who completed car	use of death (Ite	em 23a) (Type	, Print)						-	
	0 173		Dr. Mizra M. N						rive	Suite	100	G1en	Burni	ie, MD 21061
Dr. Mizra M. Nusairee, M.D. 1401 Madison Park Drive Suite 100 Glen Burnie, MD  State Registrar  SEP 2 0 2007  State Registrar														

State of Maryland / Department of Health and Mental Hygiene-1 - For State Registrar 32086 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year Month **Physician** Malarkey 11:18 cotember 1150 DEFN 11,500 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Fecility Name (If not institution, give street and number) Examiner Baltinore 1+1 HOSPITON HODKINS Johns If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Sep. 10, 1926 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 6. Sex **Funeral** Hours Davs 1 ☐ M 2 🛛 F Months 194-20-8046 81 Pennsylvania Director Usual Residence of Decedent death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County Item 27 is marked other then "natural", or Iteme 23s or 28s-1 show other traumatic event, the Mudical Examinations in the notified at MD Anne Arundel Severna Park 1 ☐ Yes 2 TNo Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 353 White Cedar Lane 21146 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ▼ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other then "naturel", or Item any injury or other traumatic event. Black, White, etc. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No White If Yes, Give Year or Dates: Specify: Specify: þ 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Matthew Dolan Theresa Weihl 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edward Malarkey/Husband 353 White Cedar Lane Severna Park, MD 21146 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State September 21 1 Durial 2 ☐ Cremation 3 □Repo al from State Media Cemetery Media, PA 4 □ Donation 5 □ Other (Specify) 2007 Signature of Funeral Septice Licenses 22. Name and Address of Facility Barranco & Sons, P.A. 495 Gov. Ritchie Hwy. Severna Park Funeral H Severna Park, MD 21146 Part / Enter the disease, it complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shook, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) bleeding **Physician** Var ICEC nous 110 /Medical Due to (or as a consequence of). Examiner HO tal Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Y601. Due to (or as a consequence Examine Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit He Dat't's
Due to (dr as a consequence of): and Division of Vital Records, P.O. Box 68760. the attending physician Physician/Medical as the IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ō Month Day Year in the past 12 months? 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No detached 9 Unknown 9 Unknown à peubis Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by page 2 should be 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? certificate 1 Yes 2**X** No 2 🗆 No 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Menner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 | Homicide within 24 hours a To the Funeral C 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of cer 29c. License number 225-000 September 17,2007 Mi) 30. Name and address of person who completed cause death (Item 23a) (Type, Print) MAHESHWARI HOSPITAL BAUTIMORE JUNN 32. Registrar's Signature 31. Date filed (Month, Day, Year) State SEP 2 0 2007 Registrar

DHMH 17 Rev 1/2001

			For State Registrar	State o	f Maryland	l / Depa <i>Cer</i>	artment of F rtificate of a	lealth and Death	Mental Hyg	iene 20	07	32087
T	Physici		1. Decedent's Name (First, Middle,	Last) I. Mulcah	ev				2. Date of Deat October	Day 200	Year	3. Time of Death 12:45 A M
	/Medic Examin		4a. Facility Name (If not institution, 226 South Car	give street and nu	mber)		4b. City, Town, or Freder		1	4c. County o	of Death	
	Funeral Director		5. Social Security Number 220–26–6185	Sex 17⊈ M 2□F	7. Age (In yrs. Ia	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		, 1931	9. Birthpla Country Mary	ace (State or Foreign
	within 72 hours are bean with the maryland than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at	rector	Usual Residence of Decedent  10a. State 10b. County  Maryland Frede  10e. Street and Number	rick		Town or Lo			1	0g. Citizen of W		d. Inside City Limits 1 XYes 2 No
1	s 23a or	ıral Diı	226 South Car				21701			U.S.A.		
2-0036	perint. Tages I are 2 should be filed within 72 thouts after death with the maryial perint. Tages I are 2 should be filed within the Martal Hygiene. Important: If them 27 is marked other than "natural", or thems 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral Director	11. Marital Status 1 □ Never Married 2 ☑ Marrie 3 □ Widowed 4 □ Divorced	Armed Fo	edent Ever in U.S proes? 2 No ve 1949–19 ates:	'	Was Decedent of H f Yes, specify Cuba 1 ☐ Yes 2☐XNo	Ispanic Origin? (San, Mexican, Puer	opecity Yes or No- to Rican, etc.)	Black	- America , White, e Whit	tc.
0-6171	within 72 he ene. than "natui he Medical	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	Education grade completed) College (	1-4or 5+)	(Give life. L	lent's Usual Occup kind of work done DO NOT use retired stodian	ation during most of wo d)	rking	16b. Kind of Bus		
N 1	and Mental Hygi and Mental Hygi Is marked other anmatic event, ti	To Be Co	17. Father's Name (First, Middle, L. John Edward	-				18. Mother's Na. Susie I	me (First, Middle, I			
, mary	ealth and N		19a Informant's Name/Relationshi M. Patricia Mul	cahey, w		226	South Ca	and Number or R arroll St	ural Route Number	rick, M	D 217	01
saitimore,	trages transition to the trant: If iter		20a. Method of Disposition  1 A Burial 2 □ Cremation 3  4 □ Donation 5 □ Other (Spa	ecify)	_ ce	t Olive	sition (Name of natory or other place et Cemetery	Oct. 5,	2007	Freder:	ick,	
מ	Depar Impor any Ir	1	21. Signature of Foreral Service Li		MOO255	K 1	eeney and 06 East (	i Basiloro Church St	d PA Fune t., Frede	ral Homerick, M	e D 217	01
E	hysician /Medical Examiner building the privale transit sthe privale transit sthe privale transit states and the privale transit states and the privale transit states are transit states and the privale transit states are transit states and the privale transit states are transit	dical Examiner	23a. Part1. Enter the disease, or can shock, or heart failure. List of immediate Cause (Final disease or condition resulting in death)  Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to Due to	each line.	ence of):  Cless ence of):	43	_	de see			Approximate Interval Between Onset and Death
X	raw requires that the death betime as been signed by the attending p 2 should be detached for use as:	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live	tcome pf pregnar birth 2  Fetai nant at time of de lown	death 3	Ectopic pregnancy Other (specify)	у		23d. Date Mon	of deliver	y Day Year
l j	een signed by nould be deta		Part II. Other significant condition			lting in the ui	nderlying cause giv	en in Part I.	23e. Did tol	e-		e cause of death?
ပ္	certificate has bee rector, page 2 sho	Completed by							24a. Was a autops perfor 1□ Yes	sy pi med?/ de	rior to com	sy findings available upletion of cause of
VITAL	ertific ector,	Be (	25. Was case referred to medical examiner?	14			la.		ath (Check only on	ne)		
ION OF	or the hours after death.  To the Funeral Director: After this certificate he completely filled in by the funeral director, page	은	1  Yes 2  No  27. Manner of Death  1  Natural 5  Pending 2  Accident investiga	28a. Date (Mor	Inpatient 2 ☐ E of Injury oth, Day Year)	ER/Outpatier 28b. Time of Injury	f 28c. Injur Wor	4 □ Nursing I	Home 5 PResidence 28d. Describe he			)
DIVISION	rs after dea al Director ed in by the	Certification;	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	ed 28e. Place build	ling, etc. (Specify,	)	eet, factory, office		28f. Location (Si City or Town	n, State)		
	in 24 hour the Funer pletely fill	Medical (	(Check only 2 Medical E	xaminer: On the b and mar	pasis of examinati iner stated.		vestigation, in my	opinion, death occ	e, and due to the curred at the time, c	date and place, a	ind due to	the cause(s)
	Total	Ž	29b. Signature and title of certifier	fague	MD.		29c. Licens D 54			October		
			30. Name and address of person was Syed W. Haque					rederic	c, MD 217	01		

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

OCT 0 5 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? 0 7 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 09 **Physician** 2007 3;00 A M Gordon Dean Madison /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Garrett Garrett County Memorial Hospital 0akland If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. 06/18/1925 9. Birthplace (State or Foreign Country) Long Beach CA. 6. Sax 5. Social Security Number 7. Age (In yrs. last birthday) Funeral Director 82 570-20-1941 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits "naturel", or itema 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Funeral Director Md Garrett Swanton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21561 119 Carmel Cove Rd. 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates: Korea Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: if frem 27 is marked other than "naturet," or Iten eny injury or other treumatic event, the Medical Exemi 1 ☐ Never Married 2 X Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: White Specify. 3 ☐ Widowed 4 ☐ Divorced Korea Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Aeronautical Engineer 17. Father's Name (First, Middle, Last) Be ( 18. Mother's Name (First, Middle, Maiden Sumame) Goldeen -- Stokes Rudolph E. Madison 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mc Henry, Md 21541 Marlene Madison/Wife P.O. Box 130 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State Omgea Crematory 9/10/07 Morgantown, Wv 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licentine 22. Name and Address of Facility Stewart Funeral Home Besty 32 South Second Street Oakland Md,21550 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Metastatic Adenocarcinoma to Lungs disease or condition resulting in death) 6 Months /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). the Hospitat or Attending Physicien: The law requires that the death certificate be executed as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Type II, Diabetes Mellitus 1 Yes 2 No 3 Probably 4 Hiknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death |Check only one| Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Medical Certification: To 1 Tratient 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 1 Natural
2 Accident 5 Pending within 24 hours efter death.

To the Funerel Director: A completely filled in by the fu investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide Techtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of cert 29c. License number 29d. Date signed (Month, Day, Year) 7,2333 10 + IVA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Thomas Johnson, MD 311 N. Fourth St., Oakland, MD 31. Date filed (Month Day, Year) 32. Registrar's Signature

DHMH 17 Rev 1/2001

State

Registrar

10

7-07637 Pasquale Moscatell	lli	Please Type or State of	Print in Bla Maryland /	Depai	rtment of	Health	and Ment	<b>opies Are Leç</b> tal Hygiene		7 0000
		For State		Cert	tificate of	Death			eg. No. 200	
Physician/ Medical Examine	1	Decedent's Name (First, Middle,Last)	Pasqua	ale M	oscate.	11i		2. Date of Deat Month Septembe	Day Year r 29, 2007	3. Time of Death 1046 hrs
price.	4	a. Facility Name (if not institution, give st 833 Summitt Avenue	reet and number)			4b. City, Tov Hagers	n, or Location of town	of Death	4c. County of Deat Washington	h
Funeral Director	1	Social Security Number 6. Sex 117-46-8114 1XM	7. Age	e (In yrs. Ia 56	st birthday) Yrs		Year If Unde Days Hours	Min	th(MM/DD/YYYY) 9. Bi Forei 6 , 1950 C	
Baltimore, MD 21215-0036  permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.  To Be Completed by Funeral Director	1 1 1 1 1	Never Married 2 X Married	st Stree  2. Was Decedent Armed Forces?  Yes 2	t Ever in U.s		10f. Zip Co as Decedent (es, specify)	21740 of Hispanic Orig Cuban, Mexican	gin? ( Specify Yes or No , Puerto Rican, etc.)	White, etc.	
5-0036 ed within 72 hours after other than "natural", he Medical Examiner Completed by '	<u> </u>	3 Widowed 4 Divorced of a 15. Decedent's Education (Specify only Elementary/Secondary (0-12)	Yes, Give Year Dates: highest grade con College (1-4 or			nt's Usual Oc lost of worki	ng life. DO NOT	kind of work done	16b. Kind of Business	/Industry
21215-0036 Jud be filed within 7 Indental Hygiene, marked other than ic event, the Medical		12				Guai			Secui	city
S. C. C. C. C. C. C. C. C. C. C. C. C. C.		7. Father's Name (First, Middle, Last)						's Name (First, Middle, ntonia Sett		
121 I be fill ental I arked vent,		Michael Mosc			101 14.75	- 4 dd				to Zin Codo)
5 21 should and Me is ma atic ev	2 1	9a. Informant's Name/Relationship (Typ		Wife)	2.0			nber or Rural Route Nur re。Schenec		
nd 2 salth a salth a 27 raum	-	Theresa A. Moscat	6111 (		Place of Dispo			Cate	20c. Location - City	
S 1a of He of He		1 X Burial 2 Cremation 3 X	Removal from St	ate St	rematory or o	ther place)	tist	October		
Page Page ment tant:		Donation 5 Other Specify:			Cem	etery		5, 2007		ady, New York
Salt ermit. Pepart mpor njury		21. Signature of Funeral Service License					ddress of Facilit	U.L. Da	vis Funeral	
		3a. Part I. Enter the disease, or complic	/iS //	014/	9 1 1	2525 I	B <u>radburu</u> dving. such as c	Ave. Smit	<i>hsburg, Mal</i> rest. shock. or heart	cyland 21783 Approximate Interval
Physician /Medical	1	failure. List only one cause on each	line.					,		Between Onset and Death
vaminer			pertensive A te to (or as a cons			liovascula	ar Disease			
	-	h	e to (or as a cons	equence o	1).					
i i	<u> </u>		e to (or as a cons	equence o	f):					
ied list		cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	e to (or as a cons	equence o	f):					4
My and T	Ĭ	dd.	, 							
s executed ian and ial - transi		UNPENDED	AMENDED							
Division of Vital Records, P.O. Box 68760, within 24 bous after death certificate be executed within 24 bous after death. To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit footsticion To De Completed by Divisional Madical Experienced Control of the Control of the Complete Bry Control of the	/sician/ine	F FEMALE: 3b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown	23c. If yes, outco  1 Live birth  4 Pregnant a  9 Unknown		2 F	etal death Other (Specia		ic pregnancy	23d. Date of deliving Month	ery Day Year
P.O. Be sthat the de gned by the detached f	[급	Part II. Other significant conditions	ontributing to dear	th but not r	esulting in the	underlying o	cause given in P		tobacco use contribute	to the cause of death?
of Vital Records, P.O. Bing Physician: The law requires that the differ this certificate has been signed by the uneral director, page 2 should be detached the Physician for the Decompleted by Dhysician and the	Completed									
an: T	20	25. Was case referred to medical				26		(Check only one)		
Vite of this of	o١	examiner? 1 ✓ Yes 2 No	spital: 1 Inpati	ent 2	ER/Outpatier			Nursing Home 5	Residence 6 🗸 Ot	ner: Scene
ling Ph		27. Manner of Death  1 ✓ Natural 5 Pending	28a, Date of Inj (Month, Day,	ury Year)	28b. Time of	Injury 28	3c. Injury at Wor		how injury occurred	
Divisior  To the Hospital or Attend within 24 bours after death to the Functor Director: completely filled in by the	Certification:	Natural 5 Pending Investigation Suicide 6 Could not be determined	28e Place of I	njury - At h	nome, farm, str	eet, factory,	office building, e			Rural Route Number, City
thin 24 ho thin 24 ho the Fune	_ 1	one) 2 Medical Examiner:	n: To the best of no On the basis of exa and manner stated	amination a	dge, death occ and/or investig	ation, in my	opinion, death o		use(s) and manner as s e and place, and due to	tated. the cause(s)
To To	₽ŀ	29b. Signature and title of certifier	ma mariner stated			29c.	License numbe	OCME	29d. Date signed (/	Month, Day, Year)
		Th. 111	Z ~	TM.			O.C.M.E.		September 30	2007
	+	30. Name and address of person who co	mpleted cause of	death (Iten	n 23a)					
5		Theodore M. King, Jr., MD.	Assistant N			111 Pe	nn Street, Ba	altimore, MD 2120	01	
Stat	te	31. Date filed (Month, Day, Year)	32. Registr	ar's Signat	ure A	alle				

			Registrar				Cei	TITICAT	e or i	veatn			Reg. No	).			
П			1. Decedent's Name (First, A	Middle, Last)								2. Date of D	eath		005	3. Time of Death	
Н	Physici /Medi		Lois Eliza	beth O'Be	erry	Y						Septem	iber "	<sup>y</sup> 23, ž	007	6:50 A. M	VI
Y	Examir		4a. Facility Name (If not instit	tution, give street and n	umber)			4b. City,	Town, o	r Location	of Death			. County of			_
			270 C Street					So1	omon	ıs			C	alver	t		
-	Funeral	П	5. Social Security Number	6. Sex	7. Age	e (In yrs. last	birthday)	If Under		If Under		8. Date of Bi	rth	9	. Birthp	lace (State or Foreig	gn
	Director		215-28-6231	1 □ M 2 💢 F		77	Yrs.	Months	Days	Hours	Min.	01-15-	1930		<sub>Соиіг</sub> Маг	yland	
	D		Usual Residence of Deceden	it												7 =	
	ylan		10a. State 10b. Co	unty		10c. City, T	own or Lo	cation							1	0d. Inside City Limits	s
	Mar fied	호	MD Ca:	lvert		Solo	mons									1 ∐Yes 2 <b>X</b> No	0
	r 288	ire	10e. Street and Number					10f. Zip	Code				10g. Cit	tizen of Wh	at Cour	itry?	_
	3a o	0	270 C Street					20	688				Iīni	ted S	tat	es	
	mus 2	Jera	11. Marital Status	12. Was De	cedent 8	ever in U.S.	13. \	_L		ispanic Ori	gin? (Spe	ecity Yes or N Rican, etc.)		14. Race -			_
·0	r Ite	Ē	1 ☐ Never Married 2 ☐	Married Armed F	2 X N	lo						Rican, etc.)		Black,	White,	etc.	
21215-0036	filed within 72 hours after death with the Maryland Hygiene. vther than "natural"; or Items 23a or 28a-f show ent, the Medical Examiner must be notified at	Completed by Funeral Director	3 XWidowed 4 ☐ Divo	If Yes. (	ive			I ☐ Yes	2 <b>X</b> No	Specify:				Specify:	Whi	te	
Ģ	2 ho	ted		edent's Education		1	6a. Deced	lent's Usua	al Occup	ation			16b. K	and of Busin	ness/Inc	dustry	
7	in 7	ple	Elementary/Secondary (0-	ighest grade completed 12) College		<u>-)</u>	(Give life. L	kind of wo DO NOT us	rk done i se retired	during mos d)	t of worki	ng					
2	y with	E E	12	(12) College	(1-401-5		House	wife					Ow	n Hom	e		
ō	othe ent,	BeC	17. Father's Name (First, Mic							18. Mothe	er's Name	(First, Middle	, Maiden	Surname)			_
Maryland	ld be lenta <b>ked</b> ic ev	ToB	Hugh Smith	Knight					-	E1i	zabe	eth Li	acre	tia :	Mon	ks	
3	should k and Ment s marked umatic e	-	19a. Informant's Name/Relat	tionship (Type. Print)		1	19b. Mailir	g Address	(Street	and Numb	er or Rura	al Route Numi	ber, City o	or Town, St	ate, Zip	Code)	_
	nd 2 Ilth a 27 is rtrau		Bonnie Collin	ns (Daughte	r)							, Mary				,	
ē,	Hea Heam term		20a. Method of Disposition	(43		20b. Place cemi				_		ate		ocation - Ci		wn. State	_
ē	Pages nent of I int: If ite		1 N Burial 2 ☐ Cremat		n State						0/27	/2007			-		
≣	it. P rtani njun		4 Donation 5 Othe			2010	mons					/2007				aryland	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Ser	vice Licensee						ss of Facili		ausch				, P.A.	
		-	000 8000 5000	nun		the treat F						by, Ma		na 20	65/		
Н			23a. Part1. Enter the diseas shock, or heart failure.	List only one cause on	each lin	ine deain. L e.	Jo not ent	er the mod	le of dyin	ig, such as	cardiac c	or respiratory	arrest,			Approximate Interval Between Onset and Death	
	Physician		Immediate Cause (Final disease or condition	_a.	COL	-ON C	AN	CER								5 months	
4	/Medical Examiner		resulting in death)			a consequen											
ß.	Examiner		Sequentially list conditions	b													
	D #	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to	or as a	a consequen	ce of):										
	n certificate be executed ending physician and use as the burial-transit	am	Cause (Disease or injury that initiated events resulting in death) Last	С													
Ö,	e exe ian a urial-	ũ	resulting in death) Last	Due to	oras a	a consequen	ce of):										
68760	ate b hysic the b	n/Medical		d											_		
9	ertific ing p	Mec	IF FEMALE:														_
30X		an/	23b. Was decedent pregnan	t 23c. If yes, or 1□Live		pf pregnancy 2 □ Fetal de	/ ath 3□	Ectopic pr	reanancy	,			1	23d. Date of		*	
	death	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ Ho		nant at	time of death	h 5	Other (sp	ecify)					Month		Day Year	
P.0	The law requires that the death the has been signed by the atter hage 2 should be detached for u	Phys	9 Unknown										-				_
Ś	as tha	Ϋ́	Part II. Other significant cor				g in the ur	derlying c	ause give	en in Part I		23e. Did	tobaccoι	use contribu	ite to th	ne cause of death?	
Vital Records,	equire en siç ould b	ba	DM, HTN	DEPRES	510	~						1 🗓	Yes 2	□ No 3	☐ Prob	abiy 4 □Unknown	n
ပ္ပ	s bee	Completed by	·									24a. Was	an	24b. We	re auto	psy findings available	e
ř	The lav e has age 2 s	Ë											ormed?/	prio dea	r to coi ith?	inpletion of cause of	
ā			25. Was case referred to pre	dical						00 Di		1□ Yes	2 <b>™</b> No	1 _	Yes	2 No	_
		Be	examiner?	Hospital:	1 Innatio		Outration	- 0 T D C	Othe	25.		(Check only					_
Ö	Phys rthis raldi	2	27. Manner of Death	28a. Date	] Inpatier e of Iniur		b. Time of			4 🗆 190		ne 5 X Res 28d. Describe			(Specif	<u>()</u>	_
	Attending r death. ector: After by the funer	ion	1 ☑ Natural 5 ☐ Pe		nth, Day	Year)	Injury	м	8c. Injun Work	k?ື Yes 2 □		Lou. Describe	now injui	ry occurred			
<u>s</u>	tten death tor: the	icat	3 Suicide 6 □ Co	ould not be	e of iniu	ry - At home	form etr					206	(044	7416			
Division or	or A ifter Direction by	Certification:	4 ☐ Homicide de	termined 200. Flac	ding, etc	(Specify)	, tarm, sur	sei, laciory	, onice		ľ	City or To	wn, State	e)	or mura	l Route Number,	
_	pital ours a eral filled		29a. Certifier 1 X Cert	tifying Physician: To th	e heet o	of my knowled	dae death	occurred	at the tir	no dato ar	d place	and due to the	20110=(=)	)		hada d	_
	Hos 24 hc Fun Fun	lica	(Check only 2 Med	ical Examiner: On the	basis of	examination	and/or in	estigation	, in my o	pinion, dea	ath occurr	ed at the time	, date and	d place, and	d due to	ated. the cause(s)	
	To the Hospital or Attending Ph within 24 hours after death.  To the Funeral Director: After th completely filled in by the funeral	Medical	29b. Signature and title of ce		nner sta	.ou.		290	. License	e number			29d Da	te signed (/	Month	Day Vest	_
	F 18 F 8		222. Signature and the of of	5				i	-	- 1 0						, 2007	
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	Registrar SEP 2 4 2007 Brews & Specific																

DHMH 17 Rev 1/2001

Natasha Prifti 07-07037 Ple UNKUNK

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

INIC OTNIC	1- For State Certific Registrar	icate of Death	Reg. No. 200	3209
Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last) Natasha Prifti		2. Date of Death Month Day Year September 10, 2007	3. Time of Death 1044 hrs
	4a. Facility Name (if not institution, give street and number) Westbound Route 50	4b. City, Town, or Location of Death Annapolis	Anne Arundel	
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last to 226 – 85 – 3455 1 M 2 K F 55	birthday) If Under 1 Year If Under 24Hrs  Months Days Hours Min	8. Date of Birth(MM/DD/YYYY) 9. Bi Dec. 29,1951	rthplace (State or gn gn puntry) Albania
nd How any Ce.	Usual Residence of Decedent  10a. State	wn or Location gfield		10d. Inside City Limits 1 Yes 2 X No
n with the Maryland ms 23a or 28a-f show be notified at once. eral Director	10e. Street and Number 6522 Lee Valley Dr. #303	10f. Zip Code 22150	10g. Citizen of What Cou	intry?
fter death I", or ite IET must Y Fun	11. Marital Status 1 Never Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? X 1 Yes 2 No 3 Widowed 4 Divorced If Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16	13. Was Decedent of Hispanic Origin? ( S If Yes, specify Cuban, Mexican, Puerto  1 Yes 2 X No specify:  3a. Decedent's Usual Occupation (Give kind of	Rican, etc.) White, etc.  Specify: Wh	
21215-0036 uld be filed within 72 hours at Mental Hygiene. marked other than "natural cevent, the Medical Examin To Be Completed by	Elementary/Secondary (0-12) College (1-4 or 5+)	during most of working life. DO NOT use ret Home Maker		
21215-0036 and be filed within 7 Mental Hygiene. marked other than e event, the M dies FO BE COMPIE	17. Father's Name (First, Middle, Last) Grigor Borshi	Emine Bo	Control of the contro	
MD and 2 sho alth and m 27 is aumati	Aurel Prifti - Son	19b. Mailing Address (Street and Number or 6522 Lee Valley Dr. #	Rural Route Number, City or Town, State 303, Springfield,  Date 20c. Location - City or Town, State 20c. Location - City or Town, State 30c.	VA 22150
Baltimore, permit Pages I ar Department of He Important: If ite	crer	natory or other place) fax Memorial Park Sep	. 17, 07 Fairfax,	VA
Physician	23a. Part I. Enter the disease, or complications that caused the death. Do failure. List only one cause on each line.	5308 Backlick Rd.,	or respiratory arrest, shock, or heart	Approximate Interval Between Onset and
/Medical xaminer	Immediate Cause (Final disease or condition resulting in death)  a. Multiple Injuries  Due to (or as a consequence of):	- 3**		Death
ted Insit Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b. Due to (or as a consequence of):  Due to (or as a consequence of):			
e execul	d. UNPENDED AMENDED			
D.O. Box 68760, that the death certificate by the attending physical detached for use as the buby Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 ✓ Unknown  23c. If yes, outcome of pregnant 1 Live birth 4 Pregnant at time of death	2 Fetal death 3 Ectopic pregn	ancy 23d. Date of delive	ry Day <b>Ye</b> ar
P.O. B res that the d signed by the be detached d by Phy		ilting in the underlying cause given in Part I.	23e. Did tobacco use contribute t	
Division of Vital Records, P.O. Box 687  To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as the fedical Certification: To Be Completed by Physician/				
ital Fisician: Sician: Si certificirector, Be C	examiner? [Hospital: 1 Innation: 2 ]	26.Place of Death (Check R/Outpatient 3 DOA Other'4 Nursi	only one)	er: Scene
on of Vital Feding Physician: ath. or: After this certificate function of the function of the function.	27. Manner of Death  1 Natural 5 Pending  28a. Date of Injury (Month, DayYear)  1. Sep 10, 2007	Bb. Time of Injury 28c. Injury at Work? 044 hrs 1 Yes 2 ✓ No	28d. Describe how injury occurred Passenger of vehicle in vehicle	cular accident
Division o spiral or Attending rours after death. neral Director: After filled in by the fune Certification;	2 M Accident Investigation 3 Suicide 6 Could not be determined (Specify) Interstate/Ex	e, farm, street, factory, office building, etc.  press	28f. Location (Street and Number or F or Town, State) Westbound Route # 50, Annapoli	
Division  To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the  Medical Certificatic	29a. Certifier 1 Certifying Physician: To the best of my knowledge, one) 2 Medical Examiner: On the basis of examination and/and manner stated.	or investigation, in my opinion, death occurred	at the time, date and place, and due to	the cause(s)
Me i i	29b. Signature and title of certifier	29c. Liœnse number O.C.M.E.	29d. Date signed (M September 11,	
n 5	30. Name and address of person who completed cause of death (Item 23 Theodore M. King, Jr., MD. Assistant Medical Exa		re, MD 21201	
State Registrai	31. Date filed (Month, Day Year) SEP 2 4 2007 SEP 2 4 2007 SEP 2 4 2007	N.		

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2007 1 - For State Registrar 32192 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death PHAM **Physician** T 062 7AM AN SEPT 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Rockville Shady Grove Adventist Hospital Montgomery If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 1 F 87 Director 1920 586-36-3449 July 4, Vietnam Usual Residence of Decedent death with the Maryland 10c. City. Town or Location 10a State 10h County 10d. Inside City Limits ral", or Items 23a or 28a-f show Examiner must be notified at 1 ☐Yes 217 No Director Maryland Rockville Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 15626 Gold Ring Way 20855 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. 72 hours after 1 Yes 2 If Yes, Give Year or Dates: 1 Never Married 28 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Asian ģ 3 ☐ Widowed 4 ☐ Divorced 'natural' Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Cashier Liquor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 1 and 2 should be fi Health and Mental H is marked Khang Danh Pham 2 Hai Thi Nguyen 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any Injury or other tra Hy Duc Dang (Spouse) 15626 Gold Ring Way, Rockville, MD 20855 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town. State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Parklawn Memorial Park 9/22/07 Rockville, Maryland 22. Name and Address of Facility DeVol Funeral Home 10 East Deer Park Drive Gaithersburg, MD 20877 Signature of Euneral Service 23a. P. rt1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sock, or he it failure. List only one cause on each line. Approximate Interval Between Onset and Death Immedia - Cara e (Final Physician RESPIRATORY FAILURE disease or condition resulting in death) MINUTES /Medical Due to (or as a consequence of): Examiner SEPSIS 2 DAYS WM 111 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine certificate be executed burial-transi and resulting in death) Last Due to (or as a consequence of) nding physician ause as the burial Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant atten for u in the past 12 months? 3 Ectopic pregnancy 4□Pregnant at time of death 9□Unknown Month Day Year 5 ☐ Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2▼ No 24a. Was an has page 2 autopsy certificate 1∐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No ٩ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) within 24 hours after death.

To the Funeral Director: After th completely filled in by the funeral 27. Manner of Death 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 0 To the Hospital within 24 hours a To the Funeral I Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) K Mulemula MD D0065819 SEPT 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9901 MEDICAL CENTER OR ROCKVILLE ALEXANDER MULAMULA 31. Date filed (Month, Day, gistrar's Signature State 2007 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No 2 0 0 7 1 - State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Vear **Physician** September 19 2007
4c. County of Death Karl David Pruitt /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Ceorge's Hospi Prince if Under 1 Year | If Under 24 Hrs. . Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months Hours Min. 1**X** M 2□ F 212-62-2400 54 Director 1/26/1952 Ohio Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hyglene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ant; Ite Medical Examiner must be notified at ury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location 10a. State 10h. County ms 23a or 28a-f show must be notified at 1 X Yes 2 ☐ No **Funeral Director** MD Seat Pleasant Prince Georges 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 6805 Drylog Street 20743 USA 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 XYes 2 □ No If Yes, Give Year or Dates: 72-74 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No þ Specify. 3 Widowed 4 Divorced White Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Motorcycle Mechanic Motorcycle Shop 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Harold Ray Pruitt <u>Lois Eunice Holcomb</u> 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: if item 27 is any injury or other trau Catherine Pruitt/Wife 6805 Drylog St., Seat Pleasant, MD 20743 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 9/24/2007 Beltsville, MD 4 □ Donation 5 □ Other (Specify) Chesapeake Crem. 21. Signature of Euneral Service License Raymond-Wood F.H., P.A. PO Box 430, Dunkirk, MD 20754 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) erative Disordo **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 🗌 Yes 2 No 3 Probably 4 driknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performed? 1□ Yes 20110 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 → Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1 Naturat 1 ☐ Yes 2 ☐ No death. 2 Accident after death Director: 6 ☐ Could not be 3 ☐ Suicide within 24 hours after de To the Funeral Directo completely filled in by th 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

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State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2007

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Year)

		,	For State of M	aryland /	-	rtment of H		Mental Hy	giene		
			Registrar		Cer	tificate of I	Death	2. Date of De	Reg. No.	2007	32094
3	Physici	an	1. Decedent's Name (First, Middle, Last)  Edward J. Patten, Jr.					Month	Day		3. Time of Death
	/Medic		4a. Facility Name (If not institution, give street and number,	)		4b. City. Town. or	Location of Death			County of Deat	
Saut.	Examir	ier	Union Hospital			E1k				Cecil	
_	Funeral		5. Social Security Number 6. Sex 7. Ac	ge (In yrs. last b	oirthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Bir	th	9 Birt	hplace (State or Foreign
M	Director		003-16-8827 1≱M 2□F	77	Yrs.	Months Days	Hours Min.	Septembe	ér 4,	, 1930 ິ	Massachusett
pug	3		Usual Residence of Decedent  10a, State 10b, County	10c. City, Toy	wn or Loc	eation					10d. Inside City Limits
Aarvis	l sho	ō	Delaware New Castle		vark						1 □ Yes 2X□ No
the	28a- notifi	rect	10e. Street and Number	110	Valk	10f. Zip Code			10a, Citi	zen of What Co	untry?
with	3a or st be	Ö	207 Cunane Circle			1970	2		US		,
d 21215-0036 filed within 72 hours after death with the Marvland	ntal Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notifiled at	Funeral Director	11, Marital Status 12. Was Decedent Armed Forces'	Ever in U.S.	13. V		ispanic Origin? (Sp	pecify Yes or No	-	14. Race - Ame	
et e	or Ite		1 ☐ Never Married 2 🛣 Married 1 🛣 Yes 2 ☐ If Yes Give	No	1	Yes 2 No	Specify:	o nican, etc.)		Black, White Specify: Wh	
500 1000	ural"; il Exa	d by	3 ☐ Widowed 4 ☐ Divorced Year or Dates:	1947 <b>-</b> 1952			121		III awa		nite
15-1	"nati	Completed	15. Decedent's Education (Specify only highest grade completed)		(Give I	ent's Usual Occup kind of work done o OO NOT use retired	durina most of wor	king	16b. Kii  -	nd of Business/	Industry
21215-0036 d within 72 hours af	than than he M	E C	Elementary/Secondary (0-12) College (1-4or	5+)		nter	'/		Indu	strial	Painting
	Hyg other	Be C	17. Father's Name (First, Middle, Last)				18. Mother's Nam	ne (First, Middle			
land be	and Mental s marked o umatic eve	To B	Edward J. Patten, Sr.				Alice Pa	aquette			
	and N Is ma auma		19a. Informant's Name/Relationship (Type. Print)	19	9b. Mailin	g Address (Street	and Number or Ru	ral Route Numb	er, City o	r Town, State, 2	Zip Code)
, <b>⊼</b>	E 17 =		Jeanette R. Rummel			unane Ci	rcle Ne		e1awa	re 1970	)2
ore	or oth		20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State	0.000.00	of Dispos tery, crem	sition (Name of natory or other plac	e) Sentemi	ber 26,	20c. Lo 2007	cation - City or	Town, State
E Ba	tment of the tant: If ite		4 ☐ Donation 5 ☐ Other (Specify)	Delawa		eterans	Cemetery	ber 20,			, Delaware
Baltimore,	Department of Heal Important: If Item 2 any injury or other once.		21. Signature of Funeral Service Licensee	/.		Name and Addres	_	T	22 W	lest_Mai	in Street
			23a. Part. Enter the discusse, or complications that cause	Le the death De						k, Dela	aware 19711 Approximate
D.			23a. Parh. Enter the dis rise, or complications that caus- shick, or heart failure. List only one couse on each		o not ente	the mode of dyin	y, such as cardiac	A billy C	1 OC	lusta	Interval Between Onset and Death
	nysician 'Medical		disease or condition resulting in death)	a consequence	ruce	J - 10	werens	1	-	To racy	
	xaminer			ocum c	e 01): , J-1	copulat a	very fort	لىدە			
195	200	Jer	Sequentially list conditions, if any leading to immediate Due to (or as	a consequence	e of):	y - Pu cespurcto		1 0			
T outed	nd ransit	Examiner	that initiated events	static	M	rall lion	vel +(a	la (c			
ŠĆ,	ian a urial-t		resulting in death) Last Due to (or as	a consequence	e of):						
68760, $\prec$	g physician and as the burial-transit	edical	d								
X C	ding g	/Me	IF FEMALE: 23c. If yes, outcome	of pregnancy							100
BOX eath cert	attending for use as	Physician/M	in the past 12 months?	2 Fetal deat		Ectopic pregnancy Other (specify)			2	23d. Date of del Month	Day Year
at the de	y the iched	ysi	1 Yes 2 No 4 Pregnant a 9 Unknown			(openny)					
s that	ned b e deta	by Pt	Part II. Other significant conditions contributing to death b	out not resulting	in the un	derlying cause give	en in Part I.	23e. Did t	obacco u	se contribute to	the cause of death?
duire	an sig	q pa		_				1 🗆	Yes 2[	□No 3√Pr	obably 4 Unknown
VITAL MECOLOS, stelan: The law requires to	s bec	Completed						24a. Was		24b. Were au	topsy findings available
r e	s certificate has birector, page 2 s	E O						autoj perfo 1□ Yes	rmed?	death?	completion of cause of
/ITa	ertific ctor,	Be (	25. Was case referred to medical examiner?				26. Place of Dea		<del></del>		
T V	this or	Tol	1 ☐ Yes No Hospital: Inpati			3 DOA Othe	4 ☐ Nursing H	ome 5□Resi	dence 6	6 □Other (Spec	cify)
	After		27. Manner of Death 28a. Date of Inju  Natural 5 □ Pending (Month, De		. Time of Injury	28c. Injun Work		28d. Describe	how injur	y occurred	
UIVISION OF l or Attending Phys	tor: /	cati	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be 288 Place of in	ium. At homo f	otro	M 1 □	Yes 2 □ No	00/ 1			
	after o	Certification:	4 Homicide determined building, e	tc. (Specify)	iaiiii, siie	et, lactory, office		City or To	vn, State	) )	ıral Route Number,
spita	nerai filled		29a. Certifier CertifyIng Physician: To the best	of my knowledg	ge, death	occurred at the tin	ne, date and place	, and due to the	cause(s)	and manner as	stated.
e Ho	within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use a	Medical	(Check only one)  2 Medical Examiner: On the basis of and manner st	of examination a	and/or inv	restigation, in my o	pinion, death occu	rred at the time,	date and	place, and due	to the cause(s)
To th	To the	Me	29b. Signature and title of certifier	0		29c. License				e signed (Monti	h, Day, Year)
			NI	. 1	FRM	DBV89	67690		001	20/07	
	_		30. Name and address of person who completed cause of	death (Item 23a)							
,	2		NITTH UEFITY, 106	04		PBBI	ELKT	014, 14	0		
	Sta Registr		31. Date filed (Month, Day, Year) 32. Reptst SEP 2 1 2007	rar's Signature	× 1	porte					
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death

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Physician /Medical Examiner

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Maryland 21215-0036

Baltimore,

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit of

Division or Vital Records, P.O. Box 68760,

To the Hospital or within 24 hours afte vertical or completely filled in completely filled in Medical Cer

3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) <sup>D</sup>18, 2007 September 5 Emilie Jane Rusinek 10:15 p M 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Anne Arundel Severna Park 205 Ritchie Hwy. If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year Oct. 3, 1 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Months 215-12-7091 1 M 2 F Maryland 85 1921 Usual Besidence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Director MD Anne Arundel Severna Park 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21146 USA 205 Ritchie Hwy. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married White 1 ☐ Yes 2X No Specify: þ 3 Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Bank Bank Officer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Harriet Morris J. Frederick Huber 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 211 Ritchie Hwy. Severna Park, MD 21146 Susan J. Cahill/Niece 20b. Place of Disposition (Name of cemetery, crematory or other place) Sept. 24, 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State MD Veterans Cemetery Crownsville, MD 2007 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Barranco & Sons, P.A. Severna Park Funeral Home Severna Park, MD 21146 495 Gov. Ritchie Hwy. nomuc Approximate Interval Between Onset and Death 23a. Pard. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. CORONARY ARTERY DISEASE

Due to (or as a consequence of): 3415 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Day Month Year in the past 12 months? 1 ☐ Yes 2 🖼 No 4☐Pregnant at time of death 5 Other (specify) 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown PULMONARY HYPERTENSION 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a. Was an autopsy performeg 2 No 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA ပို 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: 5 ☐ Pending investigation (Month, Day Year) 1 Natural 2 ☐ Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 00054739 SEPTEMBER 19th Everilly ms 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Donna M Eversley, ROAD, Sur 32. Redistrar's Signature Sute 204, GLEN BURNIE MARYLAND 2106 OAKWOON 31. Date filed (Month, Day, Year) leur. SEP 2 0 2007

			1 - For State Registrar	State of N	Maryland		artment of H tificate of I		Mental Hy	giene Reg. No.	07	320	96
	Physici	an	Decedent's Name (First, Middle, L	· ·					2. Date of De Month	eath Day	Year	3. Time of I	
	/Medi		Gretchen M. Ro						9	21		7 4:25	P <sup>M</sup>
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			Vindobona Nurs:  5. Social Security Number 6.		Age (In yrs. last	hirthday)	Braddock	Height If Under 24 Hr			dericl		Foreign
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21215-0036	72 hours after death with the Maryland "neturet", or tiems 23a or 28a-f show odical Exp citrer mark by rectified at	Completed	15. Decedent's (Specify only highest g	Education	1	6a. Dece	lent's Usual Occupa	ation	orkina	16b. Kind o	f Business/	Industry	
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Ž	2 should be filed within and Mental Hygiene. Is marked other then aurmatic event, the Mental the Mental to the Men	ို	Harvey Lee Mole			10h Mailir	g Address (Street a		ary Howe	or City or To	um Stato 7	Zio Codo)	
Maryland	d 2 s Ith an 27 is i		John H. Rollins				imes St.	Woodsb		21798	WII, JIAIO, Z	ip Code)	
	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: if item 27 is marked other then may injury or other treumatic event, item 2006.		20a. Method of Disposition		20b. Place	e of Dispo	sition (Name of		Date	-	on - City or	Town, State	
9	Pages ent of nt: If I		1 ☐ Burial 2 【XCremation 3 4 ☐ Donation 5 ☐ Other (Spec	Removal from Sta	(0		natory or other plac m Cremate	1	24/07	Hagers	r town	MD	
Baltimore,	mit. F partm portar injui		21. Signature of Funeral Service Lic		nage		. Name and Addres		24/07	nagers	COWII	MD	
ä	Depared Depared Important		Barbara A. Wi	lliams a	120		John T Wi	lliams 1	Funeral 1	Home, I	Bruns	vick MD	
3760,	ate be nysicie he bui	ı	shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, in your cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a	as a consequen	ce of	while					Interval Betwonset and D	
.O. Box 68			IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown		2 Fetal de at time of death	ath 3□	Ectopic pregnancy Other (specify)				Date of deli Month	•	ear
Q.	The law requires thet the site has been signed by the bage 2 should be detache		Part II. Other significant conditions	contributing to death	but not resultin	ng in the u	nderlying cause give	n in Part I.	23e. Did	tobacco use c	ontribute to	the cause of de	ath?
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n C	ding f	Certification:	27. Manner of Death  Natural 5 ☐ Pending	28a. Date of Ir (Month, L	Day Year) 28	b. Time of Injury	28c. Injury Work	:?	28d. Describe	how injury oc	curred		
Division	Attending ir death. actor: After by the fune	cat	2 Accident investigati 3 Suicide 6 Could not	be 200 Place of I	niuny - At home	farm ctr	M 1 1	res 2 □No	28f Location	Stroot and No	imbor or Pu	ıral Route Numb	201
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	To the Hospital or Attending Physicien: The law within 24 hours after death. To the Funeral Director: After this certificate has complately filled in by the funeral director, page 2	Medical C	29a. Certifier Check only one) Certifying F	Physician: To the bearing the basis and manner	of examination	dge, death and/or inv	occurred at the time restigation, in my op	e, date and place pinion, death occ	ce, and due to the curred at the time,	cause(s) and date and place	manner as ce, and due	stated. to the cause(s)	
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				May			74	-716	9	91:	24/2	2007	
	10		30. Name and address of person who	completed cause of	f death (Item 23	la) (Type,	Print)			9			
	1		CHAN-HING	Ho, M	0.6	100	1th AUG	BR	eunswic	KIM	150	716	
	Sta Registr		31. Date filed (Month Cay, Year)	2007 32. legis	strar's Signature	A	Print)  7 th Aug	,			,		

		•	For State Registrar		yland / Depa <i>"</i> <i>Cer</i>	tificate of L			g. No 2007	32097
	Dimini	3	1, Decedent's Name (First, Middle, Last)					2. Date of Deat	1	3. Time of Death
	Physicia /Medic	_		ICE		# 03 T		SEPTEMBE	R 21, 2007	
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No. 12	Funeral		FREDERICK MEMORI  5. Social Security Number 6. Sex	7. Age (	PITAL (In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth	Year) 9. Bir	thplace (State or Foreign
64	Director		218-34-4045 1□M	2 X F	76 Yrs.	Wolling Days	Tiodio Iviiii.	July 22	, 1931 Ma	ryland
	land ow		Usual Residence of Decedent  10a. State 10b. County	1	10c. City, Town or Loc	cation				10d. Inside City Limits
	a-f sh	ctor	Maryland Frederick		Thurmont					1 Yes 2 No
	vith the	Dire	10e. Street and Number	- moot		10f. Zip Code 21788		11	Og. Citizen of What Co	
	should be filled within 72 hours after death with the Maryland ind Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show umatic event, the Medical Examiner must be notified at	Funeral Director	426B North Church St	Was Decedent Ev	ver in U.S. 13. V	Vas Decedent of Hi f Yes, specify Cuba		ecify Yes or No-	U.S.A.	erican Indian,
٥	after d or iten niner	F	1 □ Never Married 2 □ Married	Armed Forces? 1 ☐ Yes 2 No If Yes, Give	) I	f Yes, specify Cuba □ Yes 2X No	n', Mexican', Puèrto Specify:	Rićan, etc.)	Black, Whit	te, etc.
2-003e	ural", c	d by	3. Widowed 4 □ Divorced	Year or Dates:						Thite
<u>.</u>	in 72 h	Completed	15. Decedent's Education (Specify only highest grade co.	mpleted)	(Give	lent's Usual Occupa kind of work done o OO NOT use retired	ation luring most of work )	ing	16b. Kind of Business	rindustry
7 7	d withi giene. rr thar the M	mo	Elementary/Secondary (0-12)	College (1-4or 5+)		omemaker			Own Hom	ie
lana,	be filed tal Hyg d othe event,	BeC	17. Father's Name (First, Middle, Last)	Cilhont			18. Mother's Name		•	
Z	d Men narke	ဥ	Charles Eutah Jesse  19a. Informant's Name/Relationship (Type.		10h Mailin				City or Town, State,	Zin Code)
Z Z	nd 2 sh Ith and 27 is n traun		Shirley Metz / Daugh			,			nt, MD 217	,
e,	s 1 ar		20a. Method of Disposition		20b. Place of Dispo			·	20c. Location - City or	
Ē	Page ment and: If and: If uny or		1 ☑ Burial 2 ☐ Cremation 3 ☐ Remo 4 ☐ Donation 5 ☐ Other (Specify)	oval from State	Resthaven		- 1		rederick,	-
Baltimor	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Licensee	) COR	x0. 61.	BERT EAGHRAND 5 EAST MA	ATLEY &	SON FUNE THURMONT	RAL HOMES, , MD 21788	P.A.
			23a. Part1. Enter the disease, or complication shock, or heart failure. List only one complications are complicated as the complete shock of the complete	ons that caused the	he death. Do not ente				-	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)	Sebs	sis					Onset and Death OAYS
	/Medical Examiner		resulting in death)	Due to (or + a	consequence f):	stone Fo	schoo			DAVS
Ĕ,		je.	Sequentially list conditions, if any, loading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c	Dur to (or as a)	Te Respired	1515				
	uted	Ė	Cause (Disease or injury	7 /	1chamic	1/ // //	<b>ふ</b>			
	2 5 12	a	that initiated events c			- 444				WEEK
ρΩ,	be exection and cian and surial-tra	al Examiner	that initiated events c resulting in death) Last		consequence of):	- 444				WEER
58/pn,	ficate be executed physician and s the burial-transit	dical	that initiated events resulting in death) Last c			· aaa				WEER
OX 68/60,	h certificate be exectending physician and use as the burial-tra	dical	IF FEMALE: 23c. Was decedent pregnant 23c.	Due to (or as a o	consequence of):  f pregnancy				23d. Date of de	livery
. Box 6	e death certificate be exec he attending physician and ted for use as the burial-tra	dical	d  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	Due to (or as a	f pregnancy	Ectopic pregnancy			23d. Date of de Month	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 11:38 A M 9 09 2007 ohanna /Medical 4c. County of Death Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death Examiner at the ishu omic Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Months Hours Min. 1 ☐ M 2 🔀 F 103-22-5696 79 Director 7/6/1928 Pennsylvania Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 XYes 2 No Maryland Wicomico Salisbury Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 1514 Riverside Drive 21801 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 【XNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married white 1 ☐ Yes 2 🔀 No Specify: Specify Completed by 3 X Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) switchboard operator communication 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Anna Solnek Mick Blahuta ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1107 Frederick Ave., Salisbury, MD 21801 Marie Ann Lydon/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Maryland Veterans 9/21/07 4 ☐ Donation 5 ☐ Other (Specify) Hurlock, MD Cemetery 22 Name and Address Figure 1 Home Professional Association mail re of Fundral Service Lio 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part1. Enter the disease, or complication at chock, or heart failure. List only one car se on aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sch line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Accident (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Physician/Medical Examiner that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 ponths? Month Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 2 No 3 Probably 4 Unknown 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ The 24a. Was an autopsy perform 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes SZ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 28a. Date of Injury (Month, Day 27. Manner of eath 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation Natural 2 Accident Year)

**Physician** /Medical **Examiner** 

filed within 72 hours after death with the Maryland

Maryland 21215-0036

Baltimore,

a or 28a-f show the notified at

"natural", or items 23a edical Examiner must b

the Medical

s 1 and 2 should be filed v f Health and Mental Hygie Item 27 is marked other t other traumatic event, th

Pages 1

permit. Page Department o Important: If any injury or

t: If Item 27

the burial-tran physician as t nse s for ned by the at e detached fr been signe should be d page ; certificate

requires that the death certificate be executed

Box 68760.

P.0.

or Vital Records,

Division

or Attending Physician:

this funeral After To the Hospital or Attendin within 24 hours after death.

To the Funeral Director: Af completely filled in by the fu

6 ☐ Could not be

determined

3□ Suicide

29a. Certifier (Check only one)

4 Homicide

29b. Signature and title of certifier

30. Name and address of person

State Registrar

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

who completed cause of death (Item 23a) (Type, Print)

1 ☐ Yes 2 ☐ No

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month. Dav. Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2007 Month **Physician** Joseph Robert Sherman Sept. 20, 8:50 p M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Glade Valley Nursing Center Walkersville Frederick If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours Months 1 ☑ M 2 ☐ F 216-16-0196 83 Director Jan. 12, 1924 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at Maryland Prince George's Laurel 1 Ves 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 501 Main Street #305 20707 U.S.A. Funera 14. Race · American Indian. 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours atter Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturat", or ite any injury or other traumatic event, the Medical Examine. 1 TXYes 2 □ No If Yes, Give Year or Dates: WW II 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: White 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) United States Elementary/Secondary (0-12) College (1-4or 5+) Plasterer Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lynn Newton Sherman Nola May Gosnell 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13500 Kimberley Court, Mt. Airy, MD 21771 Anna M. Hall-Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Berial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Ponation 5 ☐ Other (Specify) Fort Lincoln Cemetery 9/25/2007 Brentwood, Maryland 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 4739 Baltimore Ave., Gasch's Funeral Home, P.A. Hyattsville, MD 20781 MOINGI 3a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Due to (or as a consequence of): Physician Days disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No Month Vear 4 Pregnant at time of death 5 Other (specify) signed by the at d be detached for P.O. I 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records. <u></u> 1 Yes 2 No 3 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 24 No 2 No 1 | Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4th Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred ai or Attending P s after death. Il Director: After? Certification: Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Funeral 🖎 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

To the within 2

31. Date filed (Month, Day, State Registrar

29b. Signature and title of certifier

Jaced



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

29c. License number

D43091

29d. Date signed (Month, Day, Year)

9-24-07

Tou House Ave, Forderile MD 21701

**Physician** /Medical Examiner Examiner Physiclan: The law requires that the death certificate be executed burial-trar and the attending physician

**Physician** 

/Medical

**Examiner** 

**Funeral** 

Director

r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at

1 and 2 should be filed within 72 hours after Health and Mental Hygiene. em 27 is marked other than "natural", or Ite

permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked any injury or other traumatic ev

Baltimore, Maryland 21215-0036

Director

Funeral

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Completed

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death with the Maryland

the detached for use signed by t d be detach icate has been sig , page 2 should b funeral filled in by

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After

hours after death uneral Director:

hin 24 hours at

Hospital or Attending

Division or Vital Records, P.O. Box 68760

Physician/Medical 2 Completed 25. Was case referred to medical examiner? Be Certification: To

IF FEMALE:

26. Place of Death (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

1 ☐ Yes 2 ☐XNo 27. Manner of Death 1 Natural 5 Pending investigation 2 Accident 3 Suicide

4 ☐ Homicide

29a. Certifier (Check only 6 ☐ Could not be

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

2 ER/Outpatient 3 DOA

28b. Time of

Injury

28c. Injury at Work? 1 Yes 2 No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

onel and manner stated. 29b. Signature and title of certifier

1 🔀 Inpatient

28a. Date of Injury (Month, Day Year)

29c. License number D12121

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

September 20, 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3929 Ferrara Drive, Silver Spring, MD 20902 George F. Sengstack, MD

Registrar

31. Date filed (Month, Day, Year) 2 2007 SEP



DHMH 17 Rev 1/2001

DHMH 17 Rev 1/2001

State

Registrar

Aruna Paspula, MD 31. Date filed (Month, Day, Year)

2007

21

Olney, MD 20832

18101 Prince Philip Drive

egistrar's Signature

State of Maryland / Department of Health and Mental Hygiene 32102 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death September 19, 2007 **Physician** Harriet G. Salomon 7:20 A M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Brighton Gardens N. Bethesda If Under 1 Year If Under 24 Hrs. Social Securify Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M Director 91 048-34-6612 Feb. 6, 1916 Connecticut Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show a or 28a-f sh be notified 1 ☐ Yes 2 ☐ No Maryland Montgomery N. Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 5550 Tuckerman Lane, # 213 20852 U. S. A. Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Bace - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 'natural', or 1 ☐ Yes 2 🛣 No White Specify: δ Specify: 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) of Health and Mental Hygiene. Item 27 Is marked other than other traumatic event, the M 12 Interior Decorator Ethan Allen 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Louis Goldman Anna Rubinstein 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

— Garrett Park, 19a. Informant's Name/Relationship (Type. Print) 4716 Waverly Avenue, P.O.Box 227, Maryland 20896 Kennenth D. Salomon - Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1
Department of F
Important: If ite
any Injury or ot 1 Burial 2 □ Cremation 3 X Removal from State King David Mem Gdns 4 ☐ Donation 5 ☐ Other (Specify) 9/23/2007 Falls Church, Virginia 22. Name and Address of Facility
Danzansky-Goldberg Memorial Chapels, Inc.
11/0 Rockville Pike, Rockville, Maryland 21. Signature of Funeral Service License Donald 23a. Part1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each like he death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician Congestive Heart Failure resulting in death) /Medical Due to (or as a consequence of) Examiner Atherosclerotic Heart Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death
4□Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an performed? 25. Was case referred to medical Medical Certification: To Be 26. Place of Death (Check only one) Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{XOther} \( (Specify) \) LIVING 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 1 ANatural 28a, Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 5 Pending (Month, Day Year) investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number of certifier 29d. Date signed (Month, Day, Year) 29b. Signature and D53691 September 20, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6320 Democracy Blvd., Bethesda, Maryland Dr. Ajjay Reddy egistrar's Signature 31. Date filed (Month, Day, Year) State SEP 21 2007 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** Florence Mildred SHEAFFER Violenber 2007 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Washington County Hospital Hagerstown Year | If Under 24 Hrs. Washington If Under 1 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 1 □ M 2 🕱 F Yrs. Director 87 23 1919 Maryland <u> 214-16-0511</u> Nov. Usual Residence of Decedent 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location ?7 is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Funeral Director Maryland Washington Boonsboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8507 Mapleville Road 21713 USA Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🛛 No Specify: 2 Specify 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Secretary State Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ည Harry Earl Weagley Elsie Grace Cline 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any Injury or other trauonce. 365 W. R. Caskey Drive, Martinsburg, W. Va. 25401 JoNan Meyer - Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ■Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Rest Haven Cemetery 9/27/07 Hagerstown, Maryland 22. Name and Address of Facility Minnich Funeral Home 21. Signature of Funeral Service Licensee ames 415 E. Wilson Blvd. Hagerstown, Maryland 21740 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** estive Heav Cona disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner evelvovascu Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner and physician are the burial-t Due to (or as a consequence of): Physician/Medical IF FEMALE: . If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Mac Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has e 2 autopsy 1□ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 Inpatient Certification: To 2 ☐ ER/Outpatient 3□ DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 5 Pending investigation 1 Natural Injury 1 Yes 2 No 2 Accident Director: 3 Suicide 6 Could not be determined To the Funeral Direct
To the Funeral Direct 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only

Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760

Baltimore, Maryland 21215-0036

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State Registrar

31. Date filed (Month, Day,

Waseem

29b. Signature and title of certifier

one)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) O Pa 001

09-24-2007 Hagerstown, Marylane

29c. License number

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** Soplember Scott Sr. 2007 /Medical 4a, Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** KEGIONAL MEDICAL CENTER Wicsmics )ALISBURY If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6. Sex Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1**X** M 2□ F 295-12-9726 Yrs. Director 81 Maryland Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ms 23a or 28a-f show must be notified at 1 Yes 2 □ No Directo Maryland | Wicomico Fruitland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ? Is marked other than "natural", or items 23a or traumatic event, the Medical Examiner must be to 21826 USA 252 Sand Castle Blvd. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: White þ 3 Midowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Meonce. Elementary/Secondary (0-12) College (1-4or 5+) Church of the Nazarene Minister 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Beatrice Stallings Reynold Scott ۵ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 28114 Riverside Dr. Ext. Salisbury, Maryland 21801 Stephen Scott/son 20b. Place of Disposition (Name of cemetery, crematory or other place Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State 9/21/07 Salisbury, Maryland Shad Point Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22 Name and Address of Facility Holloway Funeral Home PA 501 Snow Hill Rd. Salisbury, Maryland 21804 Lampson Jarre Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that daused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician PHEUMONIA 3 weeks disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed for use as the burial-transi Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 □Live birth 2 □ Fetal death 4 □ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 ☐ Other (specify) signed by the a d be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No page 2 s autopsy perform certificate To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 | Yes 2 No. Certification: To this nours after death. neral Director: After this y filled in by the funeral di 28a. Date of Injury 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 2 Accident (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 redical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely . (Check only one) 29c. License number

State Registrar 29b. Signature and title of certifier

KONALD

31. Date filed (Month

30. Name and ordress of person who completed cause of death (Item 23a) (Type, Print)

Year)2007

IRMUITE

2. Registrar's Signature

255-12-9726

MD

D36576

560 RIVERSIDE DA

29d. Date signed (Month, Day, Year)

MD

0815

SALIS

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** D M /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and gumber) Examiner 64111 TIMO If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign . Social Security Number 6. Sex 7. Age (In vrs. last birthday, **Funeral** Months Days Hours 1 ☐ M 2 💢 F 65 AUG 14, 212-40-5439 1942 MARYLAND Director Usual Residence of Decedent permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10c. City, Town or Location 1 X Yes 2 □ No Director MARYLAND HARFORD **EDGEWOOD** 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 21040 1813 HARBINGER TRAIL USA Funeral 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married 1 ☐ Yes 2XNo Baltimore, Maryland 21215-0036 Specify: Specify: BLACK þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) MANAGER HOTEL 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be MABEL GREENE ပ ALBERT C. TAYLOR 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1813 HARBINGER TRAIL, EDGEWOOD, MARYLAND 21040 KEVIN TAYLOR / SON 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 9/26/07 HIGHVIEW MEMORIAL GRD. FALLSTON, MARYLAND 4 Donation 5 Other (Specify) 22. Name and Address of Facility
LISA SCOTT FUNERAL HOME, P.A.
552 LEWIS STREET, HAVRE DE GRACE, 21. Signature of Funeral Service Licenses Scett MD 21078 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Medical Due to or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): physician Division or Vital Records, P.O. Box 68760 Physician/Medical the attending IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d, Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Year Day in the past 12 months' 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) the 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 4 Unknown 1 Yes 2 No 3 Probably page 2 should Completed 24a. Was an 24b. Were autopsy findings available certificate has prior to completion of death?

1 Yes 2 No autonsy nerform Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: ✓ Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 27. Man of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident hours after death uneral Director: 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours at To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical one) and manner stated.

State Registrar 29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

s Signature

29c. License number

om Woods

29d. Date signed (Month, Day, Year)

Division or Vital Records, P.O. Box 68760, To the Hospital or Attend within 24 hours after death To the Funeral Director:

Registrar

State

HOSPICA

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

COASTAL

32. Registar's Signature

6 HULAM WARIS

31. Date filed (Month, Day,

00058410

PO BOX 1733

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** Edward Henry Utz /Medical Sept 21 2007 11:30 ຕັ 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1310 Washington Road Carroll Westminster 8. Date of Birth (Month, Day, Year) Social Security Number 7. Age (In vrs. last birthday) If Under 2 Birthplace (State or Foreign Country) **Funeral** 1 **∑M**M 2 □ F Months Days Director 216-70-2345 Usual Residence of Decedent 49 Aug 27 1958 MD 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show Examiner must be notified at 1 ☐ Yes 2 ☑ No Director MD Carroll Westminster 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 2 any injury or other traumatic event by Funeral 1310 Washington Road 21157 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 14 Race - American Indian 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ XNo Specify Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Mechanic Evapco 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Carroll H. Utz Sarah N. Bollinger 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1310 Washington Road Westminster, MD Judith Utz/wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 09/26/2007 1 Surial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Evergreen Memorial Gardens Finksburg, MD 21. Signature of Funeral Service Licenses Printed Francia Home and Chapel, P.A. 412 Washington Road Westminster, MD 21157 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner executed as the burial-transit and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 attending physician To the Hospital or Attending Physician: The law requires that the death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 □Ectopic pregnancy in the past 12 months? Month Year Day 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No the 9□Unknown 9 ☐ Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2□ No 3 robably 1 Tyes 4 ∐Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No has autopsy performed this certificate 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) /2 No 1 Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🔲 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred within 24 hours after death. To the Funeral Director: After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident n by the 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check on one) and title of certifier 29d. Date signed (Month, Day, Year) License number 29b. Signature

WIL 20

> State Registrar

31. Date filed (Month, Day, SEP 24

2007

address of person who c

Street Westmister, 40 21157

pleted cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend #1, per MD g893 7/17/09 TT

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) Oscar Armando Valenzuela Matamala 2. Date of Death Physician Month Oscar Armando VALENZUELA 0150 2007 /Medical 25 September 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington County Hospital Washington Hagerstown Social Security Number If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 224-13-5707 Director 75 June 29, 1932 Chile Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show Examiner must be notified at TX Yes 2 No Directo Maryland Washington Hagerstown 10e. Street and Number 10g. Citizen of What Country? ō Pages 1 and 2 should be filed within 72 hours after death with items 23a 1318 Glenwood Avenue 21742 Chile Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 ☐ Married ò Baltimore, Maryland 21215-0036 1X Yes 2□ No Specify. ģ Specify 3 ☐ Widowed 4 X Divorced 'natural", Chilian White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) if Health and Mental Hygiene. item 27 is marked other than other traumatic event, the M 6 Hotel Laundry attendent Hotel Industry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Oscar Armando Valenzuela 2 Concepcion Carmen Matamala 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jenny Duggan - Daughter 1318 Glenwood Avenue, Hagerstown, Md. 21742 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages Department of Important: If it any Injury or o ō 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hagerstown Crematory | 9/29/07 Hagerstown, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Minnich Funeral Home 415 E. Wilson Blvd. Hagerstown, Md. 21740 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate caus. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine or Attending Physician: The law requires that the death certificate be executed physician and s the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9☐Unknown ò signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performe certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical director Be 26. Place of Death (Check only one) examiner? 2₩ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 20 1 Tes Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Medical Certification: After (Month, Day Year) Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident within 24 hours after death

To the Funeral Director;
completely filled in by the 1 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

State

Date filed (Month, Day,

Year)

SEP

26 2007

completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygier [ ] 7 1 - For State Registrar Certificate of Death Rea. No 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day 046CM YANDO **Physician** 2007 /Medical Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Examiner 120/13 Vied NNE de If Under 1 Year | If Under 24 Hrs. | 9. Birthplece (State or Foreign Country) England 8. Date of Birth (Month, Day) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 🔀 M 2 🗆 F 6/08/1939 68 579-62-4708 Yrs. Director Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10a. State 10c. City, Town or Location item 27 is marked other than "natural", or items 23s or 28e-f show other traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 No Deale Anne Arundel Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USÁ 20751 619 Charles Ave. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Examinat once. 1 ☐ Yes 202 No If Yes, Give Year or Dates: 1 Never Married 250 Married White Baltimore, Maryland 21215-0036 1 Yes X No Specify: Specify. ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Printing Bookbinder 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last, Be Diane Johnson George Virando 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Deale, MD 20751 Wife 619 Charles Ave. Jacqueline Virando 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
1 ☐ Donation 5 ☐ Other (Specify) 9/20/2007 Baltimore, MD Metro Crematory 22. Name and Address of Facility Hardesty Funeral Home, P.A. 21. Signature of Fureral Service Licen Out. 12 Ridgely Ave. Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the attending physician and hed for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ pe 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed this certificate has been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 2 No 1 Yes or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner' Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 1 Yes 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A 2 Accident the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier and address of person who completed cause of death (Item 23a) (Type, Print) IN D

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

SEP 2 0 2007

32. Refistrar's Signature

07-07304 Ke

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

ith Larinzo	Wa	•	State State	ate of M	arylaı			ment of cate of			Menta	al Hyg		D 1	20	0	7 22	1 1
Physi	icia		Registrar 1. Decedent's Name (First, Middl	e,Last)								2	Date of D			3.	Time of Death	
edical Exa		-	Keith Larinzo										Month Septeml	Da ber 18	y Year 8, 2007		2325 hrs	
			4a. Facility Name (if not institutio Route 5 at Shortcut R		and nun	mber)		41	o. City, To Clintor		ocation of	Death			4c. County of De Prince Geor			
Funer	ral	-	5. Social Security Number	6. Sex		7. Age (In yr	s. last b	oirthday)	If Under	1 Year	If Under	24Hrs.	8. Date of	Birth(N	M/DD/YYYY) 9.		lace (State or	
Direct			262-79-7988	1 <b>X</b> M 2	F	38	3	Yrs.	Months	Days	Hours	Min.	09/11	1/19	969	eign Count	y <b>Georgi</b>	.a
		t	Usual Residence of Decedent						J									
* any			10a. State 10b. County			10c. C	-	vn or Locatio	on							- 1	od. Inside City Li X Yes 2	
laryland :8a-f show	once.	٥	MD PG				ACC	okeek	101 7	0 1			11.5	10= /	Citizen of What C			110
Mary r 28a-	ed at	Director	10e. Street and Number 1547 Shelford	Tano			-		10f. Zip (	)607				10g. 1	USA	ountry	, ,	
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ath w items	ıst pe	uneral	1 Never Married 2 XXM	arried A	rmed Fo	rces?			s, specify						White, etc			
fter de	- III	<u>ш</u> [	3 Widowed 4 Div	orced If Yes,	Yes Give Year	2 N	0	1	Yes 2	X No	specify:				Specify: B	lac	k	
ours a	2	함	15. Decedent's Education (Spe				1) 16	a. Decedent during mo						16	b. Kind of Busine	ss/Ind	ustry	
1 <b>6</b> ո 72 հ	ical E	Sete	Elementary/Secondary (0-12)	Co	llege (1-	-4 or 5+)							-/		Montgome:	<b>ν</b> τ 7	Co. Corr	, ı <u>+</u>
5-0036 ed within 7: tygiene. other than	Med	Complete	12th 17. Father's Name (First, Middle.	Last)				FIL	e Fig			s Name (	First, Middl		den Surname)	L y	<del> </del>	L
215-0036 be filed within 7 ntal Hygiene. rked other than		Bec	Norman Scurry									da Wa						ļ
m Me Me	5		19a. Informant's Name/Relations		int )		- 1	19b. Mailing	Address	(Street	and Numb	ber or Ru	ral Route N	Number	r, City or Town, S	ate, Z	ip Code)	
MD Id 2 sho Ilth and In 27 is	traumatic		Crystal A. Wa	y - Wi	ife										Marylan		20607	
	er tra		20a. Method of Disposition  1 Burial 2 X Cremation	3 <b>x</b> Rei	noval fro	om State	cren	ce of Disposi natory or oth	er place)		1		Date		0c. Location - City			
Pag Pag nent	or of	1	4 Donation 5 Other S	necify:			Hatc	her Cre		_			8/2007		Langley, S		arolina	
Baltimore, permit Pages 1 ar Department of Hes Important: If ite	nju y		21. Signature of Funeral Service	Licensee	all	)		22. N	ame and	Address	of Facility	Free	men Fur	rera	l Services	740		
Physicia		$\dashv$	23a. Part I. Enter the disease, or	domplication	s that ca	aused the de	eath. Do	not enter th	4 BOO	f dying, s	uch as ca	ardiac or	respiratory	arrest,	ryland 20 shock, or heart	740	Approximate Int	
/Medic	al	17	failure. List only one cause Immediate Cause (Final disease	on each line							*2 %						Between Onset Death	t and
`xamin	ier		or condition resulting in death)			consequen	ce of):											
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68760 certificate b	for use as the bu	sician/Me	23b. Was decedent pregnant in t past 12 months?		Live b	irth		2 Fet	tal death	3	Ectopic	pregnan	су		Month	Da	y Year	ır
Box (e death of	for us	Sici	1 Yes 2 No 9 Un	known 4	Unkno	ant at time o	or geath	5 Oth	ner (Spec	cify)				- 10	50			
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of Vital Records, ng Physician: The law require Mer this certificate has been si	hould	Completed											24a. W	/as an utopsy			psy findings ava mpletion of caus	
ecol he law ate has	- 14	m d												erforme es 2		h? <b>Ye</b> s	2 \	No
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Division tal or Attendir s after death.	n by th	ertification	. = . =	stigation 2	8e. Plac	e of Injury -	At home	e, farm, stree	et, factory	office bu	uilding, et	c.			eet and Number o	r Rura	Route Number	r, City
Division of the property of th		eri	Odioide		Specify)	Major F	Road /	Highway				F	Route 5 at	n, Stat Short	t Cut Road, Clir	nton,	MD	
Division of Vital Records, P.O. Box 68760 for the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death.	completely f	ical C	29a. Certifier 1 Certifying F (Check only one) 2 Medical Exa	hysician: To	the bes	st of my know of examinati	wledge, ion and/	death occur	red at the tion, in my	time, da	te and pla death oc	ace, and courred at	due to the d the time, d	cause(s date and	s) and manner as d place, and due	stated to the	i. cause(s)	
To t with To t	com	Medical	29b. Signature and title of certifi	and n	nanner s	tated.					e number	-			29d. Date signed			
			Conde	NC	00	Qa	u	-		O.C.N	И.E.				September 19	9, 20	07	
	0		30. Name and address of person	who comple	eted caus	se of death												
RI	1		,	sistant M			_	11 Penn S	Street, I	Baltimo	ore, MD	21201						
	<b>C</b>	76	31. Date filed (Month, Day Year)		32. Re	egistrar's Sig	dr ture	BI										

State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Physician Rosevelt Whitaker, Jr. September 20, 2007 10:50 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hyattsville 6707 - 22nd Place 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 6. Sex **Funeral** 1**⋈**M 2□F 578-76-0120 50 04/17/1957 Washington, DC Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show the Medical Examiner is ust be notified at Y☐Yes 2☐No MD Hyattsville Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20782 6707 - 22nd Place 238 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, or Itams Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Pueno Rican, etc.) 11. Marital Status Black, White, etc. within 72 hours after 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: Black þ 3 Widowed 4 Divorced "natural" 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver Covernment 2 years and Mental Hygi 18. Mother's Name (First, Middle, Maiden Sumame, 17. Father's Name (First, Middle, Last) Be should be and Mental Rosevelt Whitaker, Sr. Claree Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) s 1 and 2 of Health a item 27 le Renae Whitaker - Wife 20782 6707 - 22nd Place; Hyattsville, MD Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 permit. Pages Department of Important: If it any injury or or 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 09/27/2007 \* 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln Cemetery Brentwood, Maryland 21. Signature of Funeral Service Licens 22. Name and Address of Facility Freeman Funeral Services 4594 Beech Road; Temple Hills, Maryland 20748 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or brant failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a confequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physicien and for use as the burial-transit certificate be executed Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year 4□Pregnant at time of death 5 Other (specify) P.0. ☐ Yes 2 ☐ No detached he 9□ Unknown 9 🗆 Unknown signed by i Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 X Yes 2 □ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes 2 No Division of Vital Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၀ 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification; After 5 Pending 1 X Natural death. investigation M 1 Yes 2 No after death 2 Accident in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide To the Hospital o within 24 hours aft To the Funeral Di completely filled 🔣 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 52767 09/21/2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1400 Forest Glen Road Suite 435 Silver Spring, MD 20910 Harminder Sethi, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene 1,18,30 per dr., g872, 10/22/07 that / FH Waqas Jawad Bin Abi Waqas 1. Decedent's Name (First, Middle, Last) **Physician** 9/22/2007 6:55 -Jawad /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Holy Silver Cross Hospital Montgomery Spring If Under 1 Year Birthplace (State or Foreign Country) Social Security Number If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday, **Funeral** Min. Months Davs Hours 1 XM 2 ☐ F 415-59-5033 43 Director 1/15/1964 Pakistan Usual Residence of Decedent the Maryland 10c. City, Town or Location show 10a. State 10b. County 10d. Inside City Limits 28a-f sh notified 1 ☐ Yes 2X No Director Md. Montgomery Silver Spring 10f. Zip Code 10e. Street and Number 10g, Citizen of What Country? 'natural', or items 23a or dical Examiner must be 13924 Wagon Way 20906 Pakistan death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ Specify: Asian 3 Widowed 4 Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) is marked other than College (1-4or 5+) 5+ Physician (M.D.) Medicine other traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be Sabiha Tanweer Mansoor Ul Haq Malik 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a Rubeela Malik - Sister 13924 Wagon Way, Silver Spring, Md. 20906 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of Important: If it any Injury or c 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Maryland National 9/22/07 Laurel, Md. 21. Signature of Funeral Servi & Icensee 22. Name and Address of Facility Universal Mortuary 411 Kennedy St., N.W. Washington, DC 20011 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Metastatic Colon cancer /Medical Due to (or as a consequence of): **Examiner** bowel obstruction lawritin small Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the death certificate be executed physician and s the burial-trans Due to (or as a consequence of) Box 68760. Physician/Medical SE IF FEMALE: use 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No detached for Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) P.O. | the a 9□Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, <u>م</u> 1 Tes 2 No 3 Probably 4 Unknown certificate has been si rector, page 2 should I Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performe 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 No 1 XInpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Certification: 1 Natural 2 Accident (Month, Day Year) Injury 5 Pending 1 ☐ Yes 2 ☐ No death. investigation after death. filled in by the 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital of within 24 hours at To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 22 00065953 30. Name and address of person with of person who completed cause of death (Item 23a) (Type, Print) 1400 Forest Glen Rd. Suite 435 Silver Spring, Md. 2091 1500 32. Registrars Signature M.D. 31. Date filed (Month, Day, Year) SEP 2 4 2007 Registrar

State of Maryland / Department of Health and Mental Hygiene 2007 32113 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician**  $\mathtt{P}^{\mathsf{M}}$ 2007 21. Sept. 4:42 Samuel E. Wenck, Jr. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Howard County General Hospital Columbia Howard If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** MOM 20F 10/31/1940 Maryland Director 220 36 2011 66 Usual Residence of Decedent 10d. Inside City Limits 10a State 10b. County 10c City Town or Location Show rai', or itams 23a or 28a-f shov Examiner must be notified at 1 Yes 2 No Directo MD Baltimore Gwynn Oak the 10g. Citizen of What Country? 10e. Street and Numbe 10f. Zip Code 4 Senta Ct. 21207 **USA** Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Styles 2 □ No If Yes, Give Year or Dates: 1959–68 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. So the than "natural; or ite sort if item 27 is marked other than "natural; or ite aurnatic evant, the Medical Exametral yor other thatmatic evant, the Medical Exametral. 1 ☐ Never Married 2 ☐ Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: 2 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a, Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Facilities Coordinator T. Rowe Price 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Charlotte Piller 2 Samuel E. Wenck 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alida R. Wenck/wife 4 Senta Ct. Baltimore, MD 21207 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition permit. Pages 1
Department of H
Importent: If ite
any injury or ot 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Mother (Specify) entombment Crest Lawn Mem. Gard. 9/26/2007 Marriottsville, MD 22. Name and Address of Facility Harry H. Witzke's Family FII Inc. 21. Signature of Funeral Service Licensee M01442 4112 Old Columbia Pk. Ellicott City, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** 2 Weeks Septic Shock resulting in death) /Medical Due to (or as a consequence of) **Examiner** 4 Weeks Pneumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed burial-trar Due to (or as a consequence of) Box 68760, Physician/Medical as IF FEMALE: use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Dav jo in the past 12 months?
1 Yes 2 No 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by þe 3 Probably 4 Unknown Myelodysplastic Syndrome 1 ∏ Yes 21 No 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No Acute Renal Failure 24a. Was an page 2 s autopsy performe certificate 1 Yes 2 XNo Hospital or Attending Physician: funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☑ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 3 No 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After 5 Pending investigation 1 🔣 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident the 24 hours after deat Punerel Director: 6 Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 Homicide filled 1 XCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier completely To the Within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Sept. 21, 2007 D36974 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10724 Little Patuxent Pkwy. Columbia, MD David O. Nyantom, M.D. 31. Date filed (Month, Day, Year) State SEP 24 Registrar

			State of Maryland / Dep	eartment of Health a ertificate of Death	nd Mental H			
			Registrar  1. Decedent's Name (First, Middle, Last)	Timeate of Beath	2. Date of D	Reg. No	2007	3. Time of Death
h	Physicia /Medic		Alberta Louise WOODCOCK		Septem		22 2007	10:23 AM
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of			c. County of Death	
	Ц		Washington County Hospital  5. Social Security Number  6. Sex  7. Age (In yrs. last birthday	Hagerstown  If Under 1 Year   If Under 2	4 Hrs. 8. Date of B	irth	Washingt	on place (State or Foreign
	Funeral Director		220-52-2083 1□M 2\\ F 67 Yrs.	Months Days Hours	Min. (Month, L	ay, Year	1940 Mary	ntry)
	pu ,		Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or L	ocation				Od. Inside City Limits
	faryla shov ed at	ō					'	1 ☐ Yes 2/☐ No
	the N	Director	Maryland Washington Hago	erstown 10f. Zip Code		10g. C	itizen of What Cour	ntry?
	th with 23a o		14109 Zinnia Lane	21742		1	USA	
	tems	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	. Was Decedent of Hispanic Orig If Yes, specify Cuban, Mexican,	in? (Specify Yes or N Puerto Rican, etc.)	lo-	14. Race - Americ Black, White,	
36	a within 72 hours after death with the Maryland glene. r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at	by Fi	1 □ Never Married 2 M Married 1 □ Yes 2 M No If Yes, Give 3 □ Widowed 4 □ Divorced Year or Dates:	1 ☐ Yes 2 No Specify:			Specify: Ta	Thite
5-0036	2 hou latura ical E	ted	15 Decedent's Education 16a, Dec	edent's Usual Occupation	of wording	16b. I	Kind of Business/In	
7	within 7 iene.  than "r	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	e kind of work done during most DO NOT use retired)	or working			
22	e filed w Il Hygier other th		8 0	Homemaker 18 Mother	's Name (First, Midd		er own ho	me
and	0 E 0 %	To Be	Albert Russel Ragland		ie Lavina		,	
Mary	should and Men s marke umatic	-		ling Address (Street and Number				Code)
	and 2 lealth a m 27 is			09 Zinnia Lane,				
altimore,	ot ite		20a. Method of Disposition   20b. Place of Disposition   1 ■ Burial 2 □ Cremation 3 □ Removal from State   20b. Place of Disposition   20b.	oosition (Name of ematory or other place)	Date	20c. I	Location - City or To	own, State
	permit. Page Department of Important: If any injury or once.		4 □ Donation 5 □ Other (Specify) Rose Hi  21. Signature of Euperat Service Ligensee	.11 Cemetery 97 22. Name and Address of Facility	/26/07	Ha	gerstown	, Maryland
n n	Depart Impo			‡15 E. Wilson B				1740
	1		23a. Part1. Enter the disease, or conditional that caused the death. Do not en shock, or heart failure. List only one cause on each line.					Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	en acclus	3/62			Onset and Death
	/Medical Examiner		resulting in death)  Due to (or as a consequence of):	1 4.	SS 7411		,	
M		ē	Sequentially list conditions, if ally, leading to huniculate cause. Enter Underlying Cause (Disease or injury	elestes les	0150	-		
	cuted id ransit	Examiner						
Š,	oe exe cian ar nurial-t	i Ex	resulting in death) Last  Due to (or as a consequence of):					
09/89	w requires that the death cerificate be executed been signed by the attending physician and should be detached for use as the buriat-transit	edical	d					
XOX ROX	nding use as	n/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome pf pregnancy			ļ	23d. Date of delive	ery
ň	death of atten	Physician/M	in the past 12 months?  1  Yes 2 No  1  Yes 2 No	☐Ectopic pregnancy ☐ Other (specify)			Month	Day Year
7.	requires that the een signed by the	Phy	9 ☐ Unknown  Part II. Other significant conditions contributing to death but not resulting in the	undarlying cause given in Part I	23e Dio	Ltobacco	use contribute to t	he cause of death?
as,	signe d be d	d by	Tall II. Other significant conditions continuing to death but not resulting in the	underlying cause given in Fait i.				pably 4 □Unknown
ecords,	law requas been 2 shoul	lete			/ 24a. Wa	s an	24b. Were auto	opsy findings available
Υ.	The la	Completed			—— aut per 1∏ Yes	opsy formed? Ž <b>V</b> IN	prior to co death?	mpletion of cause of 2 No
Ita		Be C	25. Was case referred to medical examiner?		of Death (Check only	<del></del>		
0	Physiclan: r this certific ral director,	٩	1		sing Home 5 Re			fy)
	Attending Physr death. ector: After this by the funeral di	tion	1- Natural 5 Pending (Month, Day Year) Injury  2 Accident investigation		28d. Describ	a now inj	ury occurred	
VISION	Atter er deal rector by the	Certification:	3 ☐ Suicide 4 ☐ Homicide 5 ☐ Could not be determined building, etc. (Specify)	treet, factory, office	28f. Location City or T		and Number or Rura	al Route Number,
5	ital or irs afte ral Dir lled in	Cert	3. 1, "					
	Hosp 24 hou Fune stely fil	edical	29a. Certifier  (Check only one)  (Check only on	ath occurred at the time, date and investigation, in my opinion, deat	d place, and due to the th occurred at the tim	e cause( e, date a	(s) and manner as s and place, and due t	stated. o the cause(s)
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Mec		29c. License number		29d. D	Pate signed (Month,	Day, Year)
			1 = /M/10/2-le 40	D001/2	66	5	25t	07
			29b. Signature and title of certifier  30. Name and address of person who completed cause of death (Item 23a) (Type 15 SED No. 131. Date filed (Month, Day, Year) SEP 2 6 2007  32. Bygistrar's Signature	Print)	110		1.1	
	Sta	te	31. Date filed (Month, Day, Year) SFP 2 6 2007  32. Pysistrar's Signature	Trom HV	HAGERS !	m	VICE	
	Registr		SEP 2 6 2001 Seren D. A.	pull				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) Day Month **Physician** 18 07 heat/ restun erou /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death b. City, Town, or Location of Death Examiner Hospice at the Lalu .oastul alisbun WICOMICO If Under 1 Year If Under 24 Hrs 8. Date of Birth 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 7/10/1938 1 X M 2 ☐ F Days Hours 69 Director 214-34-7912 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amportant: If item 27 is marked other than "natural", or items 23a or 28a-f show any lury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10h. County 1 Yes 2 No Maryland | Wicomico Salisbury Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21804 Funeral 708 Oak Hill Ave 12. Was Decedent Ever in U.S. Armed Forces? 1 1 X Yes 2 □ No If Yes, Give Year or Dates: Marine 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXXVo Specify. Specify: ð 3 ☐ Widowed 4 ☐ Divorced White Completed 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Delmarva Power 12 Engineer Fieldman 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Martin G. Wheatley Lola Twigg 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 708 Oak Hill Ave. Salisbury, Maryland 21804 Carolyn Wheatley/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place Wicomico Memorial Park Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 9/21/2007 Salisbury, Maryland 21. Signature of Funeral Solvice Licensee 22. Name and Address of Facility Holloway Funeral Home PA 501 Snow Hill Rd. Salisbury, Maryland 21804 to Part! Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine attending physician and for use as the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) been signed by the a should be detached to ☐Yes 2☐No 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 250.No 3 Probably 4 □Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform 2 No 1 TYes To the Hospital or Attending Physician: within 24 hours after death. filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 1 Tyes 5 ☐ Residence 6 ☐ Other (Specify) 27. Mapher of Death Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Director: After (Month, Day Year) Natural 5 ☐ Pending investigation Natural Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 24 hours a CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical

To the

Registrar

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day,

SEP

30. Name and address of person who completed cause of leath (Item 23a) (Type, Print)

200

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Sept. 3:30 A M Wotring, Sr. 7, 2007 Waldo Calvin /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 01ney Montgomery Montgomery General Hospital 9. Birthplace (State or Foreign Country) West Virginia If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday **Funeral** Days Hours 1 X M 2 □ F 74 July 6, 1933 291-34-0934 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show ral", or items 23a or 28a-f sho Examiner must be notified at 1 XYes 2 No Director MD Clarksville Howard 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21029 6491 Havilland Mill Road USA Funeral 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 K Yes 2 □ No If Yes, Give Year or Dates: Korea 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: White þ 3 Widowed 4 Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) ages 1 and 2 should be filed within 72 ho nt of Health and Mental Hygiene. If item 27 is marked other than "natur or other traumatic event, the Medical. 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Superintendent Stone Quarry 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked of any Injury or other traumatic ev Sheridan Wotring Sel1 Calvin Hester ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Katherine A. Wotring/ Wife 6491 Havilland Mill Road, Clarksville, MD 21029 20b. Place of Disposition (Name of cemetery, crematory or other place Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【ACremation 3 ☐ Removal from State 9/10/07 Omega Crematory Morgantown, WV 4 ☐ Donation 5 ☐ Other (Specify) of Funeral rvice Liceus⊾e 22. Name and Address of Facility 32 S. Second St. Stewart Funeral Home Oakland, MD 21550 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final TSCHEMIC Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner ORONA RY Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed physician and the burial-tran Due to (or as a consequence of) Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown FIBRILLATION 1 ☐ Yes certificate has been si ector, page 2 should l VENTRICULAR 24a. Was an Were autopsy findings available prior to completion of cause of autopsy performed? Yes 2 No death? 1 □ Yes 2□ No or Attending Physician; 25. Was case referred to medica 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ☑ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 🗌 Yes 2 □ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide

Division or Vital Records, P.O.

Box 68760,

Baltimore, Maryland 21215-0036

To the Hospital or Attendii, within 24 hours after death.

To the Funeral Director; A completely filled in by the fu 20 IVA

4 Homicide

(Check only

- regor

31. Date Fied (Month, Day,

29b. Signature and file of certified

29a. Certifier

Medical

State

Registrar

DHMH 17 Rev 1/2001

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Shady Grove Road ROCKVIlle, MARYLAND

29d. Date signed (Month, Day, Year)

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

15335

Registrar's Signature

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Year)

10

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32.

			1 - For State Registrar	State of Ma	ryland / Depa	artment of F			giene Reg. No.2007	32117
	Physic		1. Decedent's Name (First, Middle, La Anna Virginia Wi	•				2. Date of Dea		3. Time of Death
	/Medi Examir		4a. Facility Name (If not institution, given 36620 Dixie Lyon				r Location of Death		4c. County of Dea	ith
	Funeral Director		216-22-2500	1 □ M 2XIE	(In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day Dec. 4,	r, Year) C	rthplace (State or Foreign ountry) yland
	h the Maryland r 28a-f ehow	Irector	Usual Residence of Decedent   10a. State	ry's	10c. City, Town or Lo	nicsville		1	10g. Citizen of What C	10d. Inside City Limits 1 ☐ Yes 25 ☐ No ountry?
36	within 72 hours after death with the Maryland ene. then "natural", or items 23e or 28e-f ehow te Medical Exp. niver mast by notified at	by Funeral Director	36620 Dixie Lyon  11. Marital Status  1□ Never Married 2□ Married  3☆Widowed 4□ Divorced	Road  12. Was Decedent E Armed Forces? 1   Yes 2020 If Yes, Give Year or Dates:	0	206 Was Decedent of H If Yes, specify Cuba	lispanic Origin? (Span, Mexican, Puerto	pecify Yes or No- p Rican, etc.)	Specify	
Maryland 21215-0036	be filed within 72 hor tal Hygiene. d other then "natura event, the Medical	Completed	15. Decedent's E (Specify only highest gr. Elementary/Secondary (0-12) 12	ade completed) College (1-4or 54	(Give	dent's Usual Occup kind of work done DO NOT use retired Farmer	during most of won		16b. Kind of Business  Cattle	
ryland	should be fillind Mental H marked otl umatic even	To Be	17. Father's Name (First, Middle, Last Roland  19a. Informant's Name/Relationship (	Eugene	Dyson	Address (Chank	Adel1		Lyon	T- 0.40
	s 1 and 2 if Heelth a item 27 is other tra		Shirley A. Saun.  20a. Method of Disposition  1 △ Burial 2 □ Cremation 3 □	ders/Daught	er 9410	Rycevil1	e Rd., M	echanics	r, City or Town, State, ville, MD  20c. Location - City or	20659
Baltimore,	permit. Pages Department of I Important: if Its eny injury or of		4 Donation 5 Other (Special Signature of Funeral Service Lice	(y) DS90/Q	Trinity N   1008/7   30	Name and Addre	ss of Facility	Funeral :	Waldorf, Home, P.A.	Maryland 1, MD 20622
2,09289	death certificate be executed  Wedical  Water dispersion and and as the burial-transit	edical Examiner	23a. Part1. Enter the disease, or comshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Coquentially list curuature, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as a Due (of as a Due) (of as a Due) (of as a c.		er the mode of dyin	ig, such as cardiac	or respiratory arr		Approximate Interval Between Onset and Death
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	requires been sign should be	Completed by P	Part II. Other significant conditions,	contributing to death but	not resulting in the ur	nderlying cause gro	en in Part I.		ın 24b. Were aı	o the cause of death?  robably 4  Unknown  utopsy findings available completion of cause of
Division of Vital Records,	Physician: this certifica ral director, p	To Be	25. Was case referred to medical examiner?  1 Yes 2 Nanner of Death	Hospital: 1   Inpatien	t 2 ER/Outpatien		er: 4 🗌 Nursing Ho	perform  1  Yes 2  th (Check only on  ome 5  Reside	med? death? 2 1 ☐ Yes	2 <del>2 No</del>
Division	el or Attending Ph. s after death. i Director: After thi od in by the funeral to	Certification:	1 Natural 2 Accident 3 Suicide 4 Homicide  5 Pending investigation 6 Could not b determined	(Month, Day	Year) Injury y - At home, farm, str		Yes 2 □ No		treet and Number or Ri	ural Route Number,
)	To the Hospitel or Attenwithin 24 hours after deating to the Funerel Director: completely filled in by the	Medical	29a. Certifier (Check only one)  29b. Signature and little of certified	nysician: To the best of niner: On the basis of e and manner state	examination and/or inv	occurred at the tim restigation, in my op 29c. License	pinion, death occur	red at the time, d	ause(s) and manner as ate and place, and due	e to the cause(s)
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		For State Registrar		State of	Marylan	nd / Depa	artmer	nt of H	ealth a Death	and Me	ental Hy	giene Rog. No	2007	321	8
		1. Decedent's Name	(First, Middle, Las	t)						1	2. Date of De	ath		3. Time of Dea	th
_	sician edical		L. Z	immerman						S	Month eptemb	er 1		11:29 F	М
	miner	4 = 100 51 414	not institution, give	street and numb	oer)		4b. City,	Town, or	Location of				County of Deat		
			ss Hospi						Spri				Montgo		
Fune		5. Social Security Nu		ex 7. ☑M 2 ☐ F		last birthday) Yrs.	Months Months	r 1 Year Days	If Under Hours	Min.	B. Date of Bird (Month, Da	y, Year)	Co	hplace (State or For untry)	•
Direct	or	251-54-27 Usual Residence of I	61	71	72_					A	ugust	14,	1935 Or	angeburg,	S
/land	ē		10b. County		10c. Cit	y, Town or Lo	cation							10d. Inside City Lin	mits
Man	ţ	Distric	t of Col	umbia	Τ.	Jashing	ton							ty⊡Yes 2 [	] No
h the	Director	10e. Street and Num		ишота		ACOUTINE	10f. Zip	Code				10g. Cit	izen of What Co	untry?	
I Z I 3-UU30 within 72 hours after death with the Maryland ene. then 'naturel', or items 23e or 28e-f ehow then 'naturel', or items 25e or 28e-f ehow	αje	1729 Min	nesota A	venue, S	E #3			20020	)			Un	ited St	ates	
dea	Funerai	11. Marital Status		12. Was Decede	ent Ever in U		Was Dece	dent of Hi	spanic Ori	gin? (Spec	ify Yes or No		14. Race - Ame Black, White		
s afte	<u>۲</u>	1 Never Marrie		1 ☐ Yes 2 If Yes, Give	₩No		1 🗆 Yes		Specify:		, , , , , ,		Specify: B1		
Hours	od by	3 ☐ Widowed 4		Year or Date	es:										
27 0	lete	(Specif	15. Decedent's Ed by only highest grad	de completed)		16a. Deced	kind of wo	rk done o	during most	t of working	g	16b. K	ind of Business/	industry	
with and the state of the state	Completed	Elementary/Secon years	dary (0-12)	College (1-4	or 5+)		Che	_	,			F	rivate		
Maryland ZIZIS-UUSO nd 2 should be liled within 72 hours all lilh and Mental Hyglene. 27 le marked other than "naturel", or rtraumatic event, the Medical Ears.	Be		First, Middle, Last)						18. Mothe	er's Name	(First, Middle,	Maiden	Sumame)		
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shou shou	-	19a. Informant's Nar	me/Relationship (7	ype, Print)		19b. Mailir	ng Address	(Street a	and Numbe	er or Rural	Route Numbe	er, City o	or Town, State, 2	lip Code)	_
er tra		Maggie M.	Zimmerm	an - Wif	e	1729	Minn	esota	a Ave	., SE	Washi	ngto	on, DC 2	0020	
or Here		20a. Method of Dispo	osition Cremation 3 🗀	Ramoval from St		lace of Dispo cometery, crer	natoni ori	that plan	e)	Da			ocation - City or		
Pag ment ant: I			Other (Specify		Lir	icoln M	lem.	Cemet	ery	Sept.	26, 4	007	Sulti	and, MD	
DEMILITIONE, INTERTINE A LATE SHOUSD  permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan  Deperment of Heelth and Mental Hyglene.  Important: if item 27 to marked other than "naturel", or items 23a or 28a-f show any Injury or other traumatic event, its Modical Examination is notified as	SUC.	21. Sign tuce of Fun	eral Service Licent	30000	0	/ /							al Home ton, DC	-	
		23a. Part Enter the	e disease, or comp	lications that cau	sed the deat	h. Do not ent	er the mod	de of dying	g, such as	cardiac or	respiratory ai	rest,		Approximate Interval Between	1
Physicia	an	Immediate Cause (F		Coron	ary Ar	tery I	)isea:	se						Onset and Death	1
/Medic		resulting in death)	-	Due to (or	as a conseq	uence of):					• • • • • • • • • • • • • • • • • • • •				
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death cert a attendin d for use	Ciar	in the past 12 n	nonths?	4□Pregnan	n 2 □ Feta it at time of d		Ectopic p						Month	Day Year	
that the deby the detached	hys	9 Unknown		9□ Unknow	n .						,				
The law requires that the steep section is a second by the second be detached by the second be detached.	by P	Part II. Othar signific	ant conditions co	ontributing to deal	th but not res	ulting in the u	nderlying o	ause give	n in Part I.		23e. Did to	obacco u	use contribute to	the cause of death	?
w require been sig should b	ed le										101	es 2	□No 3□Pr	obably 4 XUnkno	own
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ysician: The ris certificete director, pag	Be (	25. Was case referre	ed to medical						26. Place	of Death	Check only o				
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Invision of vital necords, for Attending Physician: The law requires taller death.  Director: After this certificate has been signe bin by the funeral director, page 2 should be e	e e	27. Manner of Death 1 ঐNatural	5 Pending		Injury Day Year)	28b. Time of Injury		28c. Injury Work			ld. Describe I	now injur	y occurred		
Seath Seath tor: /	Cat	2 ☐ Accident 3 ☐ Suicide	investigation 6 Could not be				М		Yes 2 □ l						
or Atten after deat Director:	Certification:	4  Homicide	determined	280. Place of	, etc. (Specif	ome, farm, str y)	eet, factor	y, office		- 28	City or Tov	vn, State	nd Number or Hu n)	ral Route Number,	
Hospitel Hospitel Hospitel Funerel tely filled			1፼ Cartifying Phy	/sician: To the be	est of my kno	wledge death	occurred.	at the tim	e date an	d place, ar	nd due to the	causa(s)	and manner as	stated	
• Ho: 24 h • Fur	edicai	(Check only 2 one)	Madical Exam	inar: On the basi and manne	is of examina	tion and/or inv	estigation	, in my op	inion, dea	th occurred	at the time,	date and	place, and due	to the cause(s)	
To the Hospitel or Attention within 24 hours after deal To the Funeral Director: completely filled in by the	₩ We	29b. Signature and ti	itle of certifier				29	c. License	number			29d. Da	te signed (Monti	n, Day, Year)	
_		16	agh	$\gamma \gamma$ .			-	000	510	60		G	/18/0-	7	
1		30. Name and address	ss of person who o		of death (Iten	n 23a) (Type,	Print)		- 00	<u> </u>		/	, , , ,	/	
(3)		Kanwaljit	Nagi, M			est Gle	en Rd	. Si	lver	Sprin	g, MD	2091	LO -		
	State	31. Date filed (Month	Day, Year)	Same 32. Reg											
Regi	strar	SEP 2	1 2001	Them.	D. 19	over									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 1- State Registrar Amend #8, perFH, C872, 10/22/07 TT Certificate of Death 2. Date of Death 2007 **Physician** nson /Medical 4c. County of Death City, Town, or Location of Death Examiner Baltimore tons If Under 24 Hrs 7. Age (In yrş. last birthday) **Funeral** Days 1 □ M 2**X**1F Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 1 Yes 2 No Director more 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 21 Funeral Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Completed by 3 Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, UONOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 00K ath 18. Mother's Name (First, Middle, Maiden 17. Father's Name (First, Middle, Last) Be OWY 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name Relationship (Type. Baltimore vestmont Noorman Place of Disposition (Name of ceptetery, crematory or other place) 20a. Method of Disposition Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) more 21. Signature of Funeral Service Licens Services 23a. Part1. Entertine disease, or complications that caused the death. Do not enter shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine requires that the death certificate be executed use as the burial-trans attending physician and resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Io une runeral Director: After this certificate has been signed by the atte completely filled in by the funeral director, page 2 should be detached for in the past 12 months? Month Day 4□Pregnant at time of death 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 5 ☐ Other (specify) 9□Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 21710 Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA 2 28a. Date of Injury (Month, Day Injury at Work? Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred To the Hospital or Attending 1 Natural 5 ☐ Pending investigation Injury 1 Yes 2 🗆 No death. 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the tirne, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signaty 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2 0 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 5, 12:30 A M Frances Esther Amenta October 0 2007 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Gilchrist Center Towson Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days 1 ☐ M 2 💢 F 218-44-0904 61 Feb. 4, 1946 Marylnad Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2X No Baltimore Maryland Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2 Perry Falls Place 21236 U. S. A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify. Specify 3 ☐ Widowed 4 X Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Day Care Provider Day Care 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Walter Coats Lena Watts 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Susan Amenta (Daughter) 2 Perry Falls Place, Baltimore, Maryland 21236 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 K Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gardens of Faith  $\lfloor 10/-10/2007 \rfloor$  Baltimore, Maryland 21. Signature of Funeral Service Libensee 22. Name and Address of Facility Schimunek Funeral Home Inc. 9705 Belair Rd., Nottingham, Maryland 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition SALL Gladder CAUCER ith

**Physician** /Medical Examiner

Department of Health and Mental H Important: If Item 27 Is marked oth any Injury or other traumatic even once.

**Physician** 

/Medical

Examiner

10a. State

**Funeral** 

Director

r 28a-f show notified at

"natural", or items 23a or

the Medical

filed within 72 hours after death

Pages 1 and 2 should be

Baltimore, Maryland 21215-0036

Director

Funeral

Completed by

Be

Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and burial-tran Medical Certification: To Be Completed by Physician/Medical as attending for use as certificate has birector, page 2 s funeral director.

Division or Vital Records, P.O. Box 68760,

resulting in death)	Due to (or as a consec	quence of):	J			
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that initiated events resulting in death) Last	CDue to (or as a conseq	quence of):				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf pregn. 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of c	al death 3 □Ectopic	c pregnancy (specify)		23d. Date of de Month	elivery Day Year
Part II. Other significant conditions of	contributing to death but not res	ulting in the underlying	g cause given in Part I.	23e. Did tobacce 1 ☐ Yes		o the cause of death?
				24a. Was an autopsy performed? 1  Yes 2 1	prior to death?	utopsy findings available completion of cause of s 2 □ No
25. Was case referred to medical examiner?				eath (Check only one)		1
1 Yes 2 No	Hospital: 1   Inpatient 2	ER/Outpatient 3□	DOA Other: 4 Nursing	Home 5 ☐ Residence	6 BOther (Spe	ecify) (+ 0 = 1 E
27. Manner of Death  1 ☑Natural 5 ☐ Pending  2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how in	jury occurred	
3 ☐ Suicide 6 ☐ Could not be determined		ome, farm, street, fact	ory, office	28f. Location (Street City or Town, Sta	and Number or R ate)	ural Route Number,
29a. Certifier 1 Certifying Pt (Check only one)	nysician: To the best of my knominer: On the basis of examination	owledge, death occurr ation and/or investigat	ed at the time, date and plac ion, in my opinion, death occ	ce, and due to the cause curred at the time, date a	(s) and manner a and place, and du	s stated. e to the cause(s)

State Registrar

completely filled in by the

29b. Signature and title of certifier

29c. License number 1) 25205 29d. Date signed (Month, Day, Year) October 5, 2007

30. Name and address of person who completed carse of death (Item 23a) (Type, Print)

N. Charles St. Balto and 21204

31. Date filed (Month, Day, Year) OCT 0

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) Day Physician Helen Acton 10:00 p. M October 7, 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deat Examiner Elllicott City Howard Rose Manor If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Country)
Pennsylvania Days Hours 1 □ M 2 € F 153-20-6848 85 March 25, 1922 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10d. Inside City Limits 10b. County 10c. City, Town or Location 1 ☐ Yes 2 No Maryland Howard Ellicott City Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country 21042 U.S.Á 9966 Old Frederick Rd. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify, Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify. Specify: 2 White 3 Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Healthcare Nurse 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Arling J. Kiefer Grace M. Good ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9966 Old Frederick Rd. Ellicott City, Maryland 21042 Daughter Mrs. Mary Dauber 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Burial 2 Cremation 3 P 3 ☐Removal from State 10/11/07 Belvidere, NJ Belvidere Cemetery 21. Signature of Funeral Senici 22. Name and Address of Facility
James J. Palmeri Funeral home 6602 Alpha Ave. Martins Creek, PA 18063 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Dement **Physician** years /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Year Day 4□Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown cate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an After this certificate has 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Certification: To Be Other: 1 Yes 2 No 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Inpatient 28a. Date of Injury (Month, Day Year) funeral 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? 5 ☐ Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 ☐ Accident filled in by the Director 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) . Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital o within 24 hours aft To the Funeral Di ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical completely 2 Medical Examiner: On the basis of examination and/or Investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of cert 29c. License number 29d. Date signed (Month, Day, Year) D58747 October 8, 2007

Registrar

State

Randal

31. Date filed (Month, Day, Year)

Charter Dr Columbia MD 21044

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

10700 2. Registrar's Signature

Riesett MD

OCT 0 9 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No 2007 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** 660 Park Heights Terrace ltimore 9. Birthplace (State or Foreign **Funeral** Min. 1**X**M 2□F Months Davs Hours North Carolin Director Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important; If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 1 KYes 2 No Director timore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? KHEIGHTS lerr 2121. SA Funeral Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 □ No If Yes, Give 4. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married Married Baltimore, Maryland 21215-0036 Completed by 1 ☐ Yes 2 No Specify. 3 Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) mont Aug NOM 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of 20c. Location - City or Town, State 10/9/07 Burial 2 □ Cremation 3 □ R
4 □ Donation 5 □ Other (Specify) 3 Removal from State Wings Mills 21. Signature of Funeral Service Licensee al Sei 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death such as cardiac or respiratory arrest Immediate Cause (Final disease or condition resulting in death) OVASCO **Physician** /Medical Due to (or as a consequence of): Examiner Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner burial-trans m.hs and Due to (or as a consequence of) Box 68760. attending physician certificate be Physician/Medical for use as the IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month 5 ☐ Other (specify) signed by the at d be detached for P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobaccourse contribute to the cause of death? Division or Vital Records, þ 2 □ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 performed certificate 2 funeral director, 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No Be 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 ☐ Hesidence 6 ☐ Other (Specify) 2 ER/Outpatient 3 DOA ပ 1 Inpatient To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dii 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred Injury at Work? Certification: (Month, Day 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

1010

31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

n

6701

32. Registrar's Signature

dA

Year) OCT 0 9 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item 19a per fb 9872 10-9-07 vt
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 1. Decedent's Name (First, Middle, Last) 2. Date of Death Ochher **Physician** Burwell 12:10 AM Williams 2007 Jane /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Keswick Nursing Home If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 09 10 24 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Min. Months Hours 1 □ M 2 🕱 260-24-1934 GA Director 83 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at Baltimore 1 □X es 2 □ No **Funeral Director** NA 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? U.S.A. 700 West 40st Street 21211 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes X☐ No Specify. Specify: Black Completed by 3 ☑ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Manheim al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Dry Cleaners Seamtress 3rd grade na 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Is marked othany injury or other traumatic event Be Viole Anderson George Williams 19a. Informant's Name/Relationship (Type. Print)
Anne
Harris—Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7115 Sandown Circle #103, Baltimore, Md 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Buria! 2 X Cremation 3 ☐ Removal from State Metro Crematory Inc 10/8/07 4 □ Donation 5 □ Other (Specify) Baltimore, Md 21. Si ature of Funeral Service Licensee 22. Name and Address of Facility
March F/H West hom Dava 10me 4300 Wabash Ave, Baltimore, Md 21215 23a. Part it Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Eld-stage Immediate Cause (Final disease or condition resulting in death) askeiner's disease Wasenlar **Physician** Years /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, ii any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Physician: The law requires that the death certificate be executed the burial-tran and Due to (or as a consequence of): the attending physician hed for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnapt 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months 1☐Yes 2☐No Month Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performed: 1 ☐ Yes 2 ☐ No 2 No 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 2 ER/Outpatient 3 DOA Certification: To 27. Mann f Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? or Attending To the Hospina, within 24 hours after deam.
To the Funeral Director: After and the further the furth of the f 1 atural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar

29b. Signature and title of certifier

N. ISABELLE 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

A RAPE S

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

29c. License number

013657

MACGREGOR, 700 W. 40th Street, Baltimme, Ma 21211

29d. Date signed (Month, Day, Year) Dexther 5,2007 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 1 per doc 88/2 10-9-07 vt. State of Maryland / Department of Health and Mental Hygien 7

32124 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Cleveland Butler Sr. Month Day Year **Physician** LER OCTOBER U3 2007 2:30 PM LLVELAND /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BaltIMURE FUTURE CARE CHERRY WOOD Reisterstown | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | O1 | O8 | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral №** M 2□F Months Yrs. 59 248-84-0681 SC Director Usual Residence of Decedent the Maryland worde I 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits d 2 should be filed within 72 hours after death with the Maryla it and Mantal Hygiene. T?? I marked other than 'natural', or (teme 23s or 28s-1 ehow traumatic event, it wholes Examine must be rediffied in 1 ☐ Yes 2 ☑ No Director MD Baltimore Owings Mills 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 9407 Planetree Cir Apt 407 21117 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 No If Yes, Give X No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 🍎 No Specify: Specify: Black 3 ☐ Widowed 4 ☑ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 2yrs Office Manager 12th grade Insurance Agency 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be permit. Pages 1 and 2 should be Deportment of Health and Mental Important: If fleen 27 te marked any njury or other traumatic eventage. Annie T. Bolden William Butler Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 7 Rushvine Ct, Owings Mills, Md 21117 Karen Pratt-Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metro CrematoryInc 10/8/07 Donation 5 Other (Specify) Owings Mills, Md 21. Signature of Funeral Service Ucensee March F/H West 4300 Wabash Ave, Baltimore, Md 21215 23a. Part1. Entar he disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner years Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): physician and the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760, Physician/Medical as the l attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 Other (specify) the Division of Vital Records, P.O. detached 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed2 1 ☐ Yes 2 ☑ No the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of eath Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No ٥ this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification; After 5 Pending investigation 1 Natural Injury death. 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (Check only one) within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certific 30. Name and address of person Sparle 1 836 who completed cause f death (tem 23a) (Type, Print) Greene Tree 21208 (enne 31. Date filed (Month, Day, Year) legistrar's Signature State 09 2007 Coff of the Registrar

Baltimore, Maryland 21215-0036

OCTOBER 2, 2007 10:15 p.m.

Division or Vital Records, P.O. Box 68760,

DARRELL BELTON

		Plea  1 - State Registrar	State of M	aryland / Depa		ealth and M	lental Hygi		0 <b>7</b>	32125
Physicia /Medic		1. Decedent's Name (First, Middle Darrell	le, Last)	•	Belto	n	2. Date of Death Month 10	-	2007	3. Time of Death 10:15p M
Examine		4a. Facility Name (If not institution	,		4b. City, Town, or L			4c. County		
Funeral		Stella Maris 5. Social Security Number		ge (In yrs. last birthday)		If Under 24 Hrs.	8. Date of Birth		1timo	ace (State or Foreign
Director		215-46-6876 Usual Residence of Decedent	1 <b>X</b> M 2 □ F	60 Yrs.	Months Days	Hours Min.	12 31	46	Count	MD MD
laryland show	'n	10a. State 10b. County MD NA		10c. City, Town or Lo	cation				10	0d. Inside City Limits 1X Yes 2 □ No
leath with the Marylan ns 23a or 28a-f show must be notified at	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of		
s 23a nust b	al	4549 Marble B			212				S.A.	1. (*)
or iten	by Funeral	11. Marital Status  1 Never Married Marr  3 Widowed 4 Divorced	If Yes, Give	Ever in U.S. 13.	Was Decedent of His If Yes, specify Cuban, 1 ☐ Yes 2 No	panic Origin? (Spe , Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		ce - America ck, White, e v: B]	
72 hour	Completed b	15. Deceden	Year or Dates:  nt's Education est grade completed)	16a. Dece	dent's Usual Occupat kind of work done du DO NOT use retired)	ion Iring most of worki	ina I	6b. Kind of B	usiness/Ind	ustry
within ene. than '	du	Elementary/Secondary (0-12)	College (1-4or	5+) life.	·			I	Doot	Office
Hiled Hygid Other ent, th	Be Co	12th grade 17. Father's Name (First, Middle,	4yrs , Last)	<u>.                                    </u>	Clerk	18. Mother's Name				Office
uld be Venta Irked Itic ev		Milton Beltor	n			Bertha	Mae Wo	rrell		
and 2 should be salth and Mental n 27 is marked o		19a. Informant's Name/Relations			ng Address (Street an				•	
Healthern 1 and 1	1	Gloria Beltor 20a. Method of Disposition	n-wife		Marble  osition (Name of matory or other place)			Ltimo:		
tment of trant: If ite		1 Donation 5 ☐ Other (S	Specify)	Garrison	Forest	Vet 10/			•	lls, Md
permit. Departr Imports any Inji		21. Signature of Funeral Service	Licensee	M M	2. Name and Address larch F/H .300 Waba	West	Balti	more,	Mđ	21215
Physician /Medical		23a. Par . Enter the distance, or sho k, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	a. COLON C	ANCER	ter the mode of dying,	, such as cardiac o	or respiratory arre	st,		Approximate Interval Between Onset and Death
be executed cian and purial-transit	lical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Gause (Disease on injury that initiated events resulting in death) Last	b. Due to (or as	a consequence of): a consequence of): a consequence of):						
attendin	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal death 3	Ectopic pregnancy Other (specify)	-			ite of deliver	ry Day Year
n requires that the d been signed by the should be detached	ò	Part II. Other significant condition	ons contributing to death b	out not resulting in the u	nderlying cause given	in Part I.				e cause of death?
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lan: T	e	25. Was case referred to medical	ul			26. Place of Death	1 Yes 2 1 (Check only one	**	1 □ Yes	2 ∐ No
ding Physiclan: The lav.  After this certificate has funeral director, page 2	10 B	examiner? 1 ☐ Yes 2 🙀 No		ent 2 ☐ ER/Outpatier		4 L. Nursing Ho	me 5 Reside	nce 6 <b>X</b> Oth	ner (Specify	HOSPICE
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or Atten after deat Director: in by the	Certification:	2 ☐ Accident Investig 3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determ	not be 28e. Place of in	ury - At home, farm, str tc. (Specify)			28f. Location (Str City or Town,	eet and Numb State)	per or Rural	Route Number,
	Medical Ce	29a. Certifier (Check only one)  1	ng Physician: To the best Examiner: On the basis of and manner st	of examination and/or in	h occurred at the time	e, date and place, nion, death occurr	and due to the ca	use(s) and mate and place,	anner as sta and due to	ated. the cause(s)
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			- /		0	4372	5	10/3	5/07	
8x1		30. Name and address of person			Print)					
Stat	e_	DR. TARIQ MAR 31. Date filed (Month, Day, Year)	32 Registi	DULANEY VAI	LEY RD.	TIMONIUM,	, MD 210	93		
Registra		OCT 0 9	2007	rar's Signature						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-Certificate of Death 1 Decedent's Name (First Middle, Last) 2. Date of Death **Physician** Burrar 07 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner MOVYLI (ento Kalvaallstowi 8. Date of Birth (Month, Day, 12 26 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Hours Days XIM 2DF Director 82 225-26-3168 Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. The marked other than "natural", or items 23a or 28a-f show ant: if Item 27 is marked other than "natural", or items 23a or 28a-f show ant: if the 27 is marked other than "natural" or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County X Yes 2 □ No Baltimore MD NA Director 10e. Street and Number 10g. Citizen of What Country? U.S.A. 21215 3714 Dolfield Ave by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1▼ Yes 2 No If Yes, Give 14 Bace - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify Specify: Black 3X Widowed 4 □ Divorced Year or Dates Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) AP Publications 6th grade Truck Driver na 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lillian Henderson David Burrow ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21215 3714 Dolfield Ave, Baltimore, Md Ronade Johnson-Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Important: If Ite any Injury or ot 1 Deurial 2 □ Cremation 3 □ Removal from State Garrison Forest Vet 10/15/07 Owings Mills, Md 4 Donation 5 Other (Specify) 22. Name and Address of Facility
March F/H West Signature of Funeral Service Licensee Baltimore, 21215 4300 Wabash Ave, 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mme if the Cause (Final use e or condition resulting in death) Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and a be detached for use as the burial-trai Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, by Physician/Medical IF FEMALE: . If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 4□Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9□Unknown 9 I Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2□ No 1 ☐ Yes 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy perform certificate 1□ Yes 2□No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) To the Hospina. C. within 24 hours after death.
To the Funeral Director: After this c 1 Yes 2 No 1 🗀 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury 27. Mannes of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide determined 29a. Certifier 🖅 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar 29b. Signature and title of certifier

30. Name and address of person

31. Date filed (Month, Day, Year)

OCT 0 9

2007

who completed cause of death (Item 23a) (Type, Pri 32 Registrar's Signature

29c. License number

29d. Date signed (Month, Day, Year)

2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician 2007 Dorothy L. Booze /Medical Facility Name (If not institution, give street and 4b. City Town, or Location of Death 4c. County of Death Examiner BALTIMORE lagel arel ente 8. Date of Birth (Month, Day, Sept. If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Months 4, 1918 Maryland Days Hours 89 217-05-5370 Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10b. County 10d. Inside City Limits r 28a-f show Maryland 1 □Yes 2 No Baltimore Be Completed by Funeral Director Parkville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7 is marked other than "natural", or items 23a or traumatic event, the Medical Examiner must be 8800 Walther Blvd United States Of America 21234 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2.7 If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 2 No 1 🗌 Yes 2Z No Specify: 3 Widowed 4 Divorced Specify: White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Secretary Leonard Grief 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Henry Graf Pages 1 and 2 should ဥ Julia C. Graf 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Important: If item 27 any Injury or other tr once. 2710 Superior Ave. Parkville, MD 21234
e of Disposition (Name of Date 20c. Location - City or Town, State Henry Graf- Brother Itimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Parkwood 9/07 oct. Parkville, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
EVANS FUNERAL CHAPEL & CREMATION SERVIORS Tatuaamis 8800 Harford Road Parkville, Maryland 21234 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** 1-na stose /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner VIII ONO Z attending physician and for use as the burial-tran Due to (or as a consequence of): Box 68760, IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Year 4□Pregnant at time of death 5 ☐ Other (specify) cate has been signed by the a page 2 should be detached Ö 9 Unknown ۵ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 Yes 2 No 3 Probably 4 Nonknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autoosy perform or Vital 2 No funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 1 Tyes 2[ No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Inursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Natural 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 ☐ Pending investigation To the Hospital or Attendir within 24 hours after death.
To the Funeral Director: At completely filled in by the fu 1 Tes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 🛮 🚾 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29c. License number 29b. Signature and little of confifier 29d. Date signed (Month, Day, Year) 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Blod, Parkville MD 21234 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar OCT 0 9

	_	State of Ma State of Ma State of Ma State of Ma State of Ma Registrar	718789789 	ertificate of	Death			
Physici /Medio	cal	Charles Wesley Barne  4a. Facility Name (If not institution, give street and number)	es, Sr.	4h City Town	r Location of Death	2. Date of Dea Month Oct.	Day Year 7 200	7 5:45P.
Examir Funeral Director	ner	Transitions Health Care (	Center (In yrs. last birthday 91 yrs.	Sykest	ville	8. Date of Birth (Month, Day NOV • 29	Carrol:	
e Maryland Sa-f show	Director	10a. State 10b. County MD Carroll	10c. City, Town or t		stminster			10d. Inside City Limit 1 □ Yes 2 図 No
th with th	al Dire	10e. Street and Number 4349 Salem Bottom Road		10f. Zip Code 2115	57	1	Og. Citizen of What C United St	•
d within 72 hours after death with the Maryland jiene. Ir than "natural", or Items 23a or 28a-f show Ite Medical Evardinar must be notified at	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent E Armed Forces?  1 Yes, Sive Year or Dates:	ver in U.S. 13	. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2CXNo	lispanic Origin? (Sp an, Mexican, Puerto Specify:	pecify Yes or No- Rican, etc.)	14. Race - Am Black, Wh Specify: Wh	ite, etc.
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be file ital Hyg od othe evant,	To Be C	17. Father's Name (First, Middle, Last)  John Stem Barnes			18. Mother's Nam	e (First, Middle, le Picket	Maiden Surname) <b>t</b>	
ges 1 and 2 should it of Health and Mer If item 27 is marke or other traumatic		19a. Informant's Name/Relationship (Type, Print) Barbara Barnes Wife	434	9 Salem E	Bottom Roa	ad West	r, City or Town, State, Minster, MI	21157
permit. Pages 1 Department of H- important: If iter any injury or otf		20a. Method of Disposition  1 □ Burial 2 ⊠Cremation 3 □ Removal from State  '4 □ Donation 5 □ Other (Specify)	South Ca		ematory O	ct. 9, 2	20c. Location - City o	eld, MD
permit Depar impor any ir		21. Signature of Funeral Service Licenses  AUU  Ball Ball Ball Ball Ball Ball Ball Bal		Burrier-Qu	ieen Funei	ral Home	& Cremato	Road 21784 ry, PA
Physician /Medical Examiner portion and prival-transit	Examiner	shock/or heart failure. List only one cause on each line immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	consequence of):	_				Interval Between Onset and Death
The law requires that the death certificate be used has been signed by the attending physicial bage 2 should be detached for use as the buri	Physician/Medical I	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Fetal death 3	□Ectopic pregnancy			23d. Date of de Month	elivery Day Year
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or To con		29b. Signature and title of certifier		D43	3725		10 [8]	o to the cause(s)  ith, Day, Year)  07  21157
6		30. Name and address of person who completed cause of de TARIA MAHMUUD	ath (Item 23a) (Type	Print)	ol Wo	ctmin	NO MI	21157

# BARENBURG KNOWN AS BURENE PATIENT

		1-	For State Registrar	State of Maryland		ment of H ficate of L			giene Reg. No <b>2</b> 0 0 7	32129
Phy	/sician		Decedent's Name (First, Middle, Last)	2 1				2. Date of Dea	ath Day Year	3. Time of Death
//	ledical		Facility Name (If not institution, give si	treet and number)	ueg 1	City Town or	Location of Deat	OCTOBE	R 4 200 4c. County of De	
Ex	aminer		INAL HOSPITAL	OF BALTIMO		BALTIM		CITY	4c. County of De	auı
Fun Direc	,	10	10 27 7021	7. Age (In yrs. Ia M 2□F 84		Under 1 Year onths Days	If Under 24 Hrs Hours Min.	8. Date of Birt (Month, Da	h, Year) 9. B	irthplace (State or Foreign Country)
land			ual Residence of Decedent  a. State 10b. County	10c. City,	Town or Locati	on				10d. Inside City Limits
e Man	cto di		MD	Ba	th more	City				1 Yes 2 No
vith th	be nouried Director		e. Street and Number			10f. Zip Code	.2.00		10g. Citizen of What C	Country?
ns 23g	Iner must	11.	Marital Status 1	/ CRRACE 2. Was Decedent Ever in U.S	. 13. Was		1209 spanic Origin? (S	pecify Yes or Noto Rican, etc.)	14. Race - An	nerican Indian,
affer or item	Fur		1 Never Married 2 Married	Armed orces? 1 ☐ Yes 2 ☐ No If Yes, Give		es, specify Cuba	n, Mexican, Puèr Specify:	to Rićan, etc.)	Black, Wh	ite, etc.
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d 21215-0036 filled within 72 hours after death with the Maryland Hygiene. sther than "natural", or items 23a or 28a-f show	Completed	E	(Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4or 5+)	(Give kind	d of work done d NOT use retired,	urina mast of wa	rking	TOD. KING OF BUSINESS	or modelary
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e, N 1 and Health em 27		208	a. Method of Disposition	- Wife	Ce of Disposition	Ivy De	ve lerr	Ace Bo	20c. Location - City of	MD Z1209
			1 ☐ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	000	metery, cremato	ory or other place	») ~// /0 -		Baltimore	
Baltimore, permit. Pages 1 at Department of Hea	any injury o	21.	. Signature of Funeral Service License	e	22. N	ame and Addres	7-4	radley.	- Askton F	Funeral Home
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/Medi	cal		sease or condition sulting in death)	Due to (or as a conseque		STASE	S.			3 YEARS
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la petro	Examiner	cat Ca tha	quentially list conditions, nny, leading to immediate use. Enter Underlying use (Disease or injury at initiated events c.	540 10 (01 40 2 0011000440						
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<b>58760,</b> ficate be ex	s me ou		d.							
Box 6 leath certific	sician/Me	IF I 23t	b. was decedent pregnant	lc. If yes, outcome pf pregnan- 1 □ Live birth 2 □ Fetal o	cy	topic pregnancy			23d. Date of d	elivery
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Division or Vital Records, I or Attending Physician: The law requires the after death.  Director: After this certificate has been signed.	ed by							101	res 2□No 3☑	Probably 4 Unknown
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Vital Rec siclan: The law certificate has b	e Cor		Was case referred to medical				00 51(5-	1□ Yes	2 MNo 1 LIY€	es 2 No
Or Vita Physiclan: rthis certifica	To Be C		examiner?	ospital: 1 Inpatient 2 □ E	R/Outpatient :	3 DOA Othe	r·	ath <i>(Check only o</i> forme 5 ☐ Resid	<i>ne)</i> dence 6 □Other (Sp	pecify)
Sion or tending Physicath.	on:		Manne of Death  ¹ ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work		28d. Describe I	now injury occurred	
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Division To the Hospital or Attending within 24 hours after death. To the Funeral Director: After	Medical Certifi		a. Certifier 1 ertifying Physi (Check only one) 1 Medical Examin	ician: To the best of my know er: On the basis of examination and manner stated.	ledge, death oc on and/or invest	curred at the tim tigation, in my op	e, date and plac pinion, death occ	e, and due to the urred at the time,	cause(s) and manner date and place, and d	as stated. ue to the cause(s)
To the within 2 To the	Me	291	b. Signature and title of certifier	_		29c. License		1	29d. Date signed (Mo.	
		-	Name and address of the	M·D·	Ogal (Time Dit	RES	000	'	OCTOBER 4	400 4
it			Name and address of person who comes of the second	TA MD	SINA I	1405	PITAL	OF BA	ALTIMOR	Ē
Re	State gistrar	31.	Date filed (Month, Day, Year) OCT 0 9 2007	3 Abgistrar's Signatu	lire Angul	0.				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

07-07671 Mary Burke

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1. For State Certificate of Death Registrar Decedent's Name (First, Middle,Last) Physician/ 2. Date of Death Month Day October 1, 2007 0005 hrs **Medical Examiner** Mary Theresa Burke 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City Town, or Location of Death St. Agnes Hospital Raltimore N/A 5. Social Security Number If Under 1 Year | If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** 6. Sex 7. Age (In vrs. last birthday) Foreign Months Days Hours Director JUL 15 1962 Country) NC 45 215-84-6491 M 2X F Yrs Usual Residence of Decedent 10d. Inside City Limits 10c City Town or Location 10a State s 23a or 28a-f show e notified at once. 1 Yes 2 X No MD Baltimore Catonsville t. Pages 1 and 2 should be filed within 72 hours after death with the Maryland timent of Health and Mental Hygiene.
rtant: If item 27 is marked other than "natural", or items 23a or 28a-f sho Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21228 USA 311 Glenrae Drive Funeral 11 Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 12. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 Never Married 2 Married Yes Yes 2 X No specify: White 3 Widowed 4 X Divorced If Yes, Give Year Specify: <u>ح</u> 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 11 Hospitality Waitress 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Adams Bobby L. Halstead Sara 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) other traumatic Stephanie Burke - daughter 311 Glenrae Drive, Catonsville, MD 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition 20c. Location - City or Town, State Itimore, crematory or other place) 2 X Cremation 3 Removal from State Burial Metro Crematory, Inc. 10/5/2007 Baltimore, MD 4 Donation 5 Other Specify 5 22. Name and Address of Facility

Cremation Society of Maryland,
299 Frederick Road, Baltimore; 21. Signature of Funeral Service Licensee Williams 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and failure. List only one cause on each line /Medical Death Cocaine intoxication Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last flospital or Attending Physician: The law requires that the death certificate be executed and Physician/Medical physician a X UNPENDED ^\mathbb{A}\_a,PII,27,28a-f, perME,g872, 10/11/07 TT Box 68760, 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Live birth Fetal death Month Day Year Pregnant at time of death Other (Specify) 1 Yes 2 No 9 V Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ó þ σ. Yes 2 No 3 Probably 4 ✔ Unknown Hypertensive atherosclerotic cardiovascular disease Completed Division of Vital Records, ficate has been s page 2 should b 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? certificate ✓ Yes 2 2 No No 1 V Yes 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Hospital: Other<sub>4</sub> Nursing Home 5 Residence 6 Other Inpatient 2 V ER/Outpatient 3 DOA After this 1 ✔ Yes 28a. Date of Injury (Month, Day, Year 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Natural Pending Yes 2 X No filled in by the f FNd 9/30/2007 Fnd 11:10 pm 2 Accident Investigation a 24 hours after d 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 6 X Could not be 311 Glenrae Dr. Catonsville, MD Suicide determined (Specify) found in residence Homicide 29a. Certifier 1 (Check only one) 2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the within : To the and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie O.C.M.E. October 1, 2007 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Melissa Brassell, MD Assistant Medical Examiner

State Registrar

31. Date filed (Month, Day, Year,

Registrar's Signature

**ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Dav **Physician** Burris-Pfarr Beverly A. 8:35 A M 4,\_ 2007 October /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 7618 Gough Street Colgate

If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. Baltimore Co. 5. Social Security Number 7. Age (In yrs. last birthday 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 1 □ M 2 ₽ F 62 213-46-4425 Director Dec. 4,1944 Maryland Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 21 No Raltimore Colgate Maryland Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States death v Funeral 7618 Gough Street 21224 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after Yes 2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify þ White 3 Widowed 4 Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Years Salesperson Retail 18. Mother's Name (First, Middle, Maiden Surname) Ukn. 17. Father's Name (First, Middle, Last) Be ould be fi Mental F f Health and Menta Item 27 is marked Frederick Buckhite Pages 1 and 2 should ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7618 Gough Street Baltimore, Maryland 21224 Mr. William V. Pfarr/Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: if ite
any injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Corp. 10/6/2007 Towson, Maryland 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc.
7922 Wise Ave. Dundalk, Maryland 21222 icuature of Funeral Service Licensee 23a Perfl. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) COPD evacerba **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) death certificate be executed and burial-trar Due to (or as a consequence of): Box 68760, physician Physician/Medical the use as attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 5 ☐ Other (specify) 4☐Pregnant at time of death signed by the a P.O. I 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy perform certificate 1∐ Yes 2□ No ospital or Attending Physician: The hours after death.
uneral Director: After this certificate by filled in by the funeral director, pa 2 4 10 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ů 5 Residence 6 □Other (Specify) 27. Marrier of Death 28a. Date of Injury 28h. Time of Certification: Injury at Work? 28d. Describe how injury occurred 1 Natural (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funeral C Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Registrar DHMH 17 Rev 1/2001

State

29b. Signature and title of certifier

31. Date filed (Month, Day,

OCT 0 9 2007

29d. Date signed (Month, Day, Year)

Philadelphia Rd. Sute 108

and manner stated.

Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TAN ASLO

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year BREWER 02, 19:24 FOOS TRUDY October 4c. County of Death 4a. Facility Name (If not institution, give street and number) . 4b. City, Town, or Location of Death Johns LOOKINS 105 Baltimure N/A Year If Under 24 Hrs. 8. Date of Birth
Days Hours Min. (Month, Day, Year)
March 3,1941 9. Birthplace (State or Foreign Country) Pennsylvania If Under 1 5. Social Security Number 7. Age (In yrs. last birthday, Days Months 1 □ M XXF 216-36-5606 66 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 DWes 2 □ No Maryland N/A Baltimore City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5086 Orville Avenue 21205 United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🖾 No Specify Specify: 3 ☐ Widowed 4X Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Johns Hopkins Elementary/Secondary (0-12) College (1-4or 5+) Physician Billing Specialist Hospital 12 Years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ada Elaine Sommerfield James Russell Carter 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, Maryland 5086 Orville Avenue 21205 Teresa Brewer (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 XI Cremation 3 ☐ Removal from State 5 ☐ Other (Specify) 4 ☐ Donation Hilltop Service Corp. 10/6/2007 Towson, Maryland 21. Signature of Juneral Service License 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. reo 7922 Wise Ave. Dundalk, Maryland 21222 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure is only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Hepa+Pc 48 hrs Encephalopath Du to (or as a consequence of): circhos Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last chkanic Hepa H YCGRS Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 Yes 2 No Month Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performe 1□ Yes 2 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one)

Physician /Medical Examiner

**Physician** 

/Medical

**Examiner** 

**Funeral** 

Director

r 28a-f show notified at

"natural", or items 23a or idical Examiner must be i

other traumatic event, the Medical

at Hygiene.

is 1 and 2 should be fill Health and Mental H tem 27 is marked oth

permit. Pages 1 an Department of Heal Important: If Item 2 any Injury or other

Baltimore,

P.O. Box 68760,

Division or Vital Records,

filed within 72 hours after death

Director

Funeral

Completed by

Be

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Examiner

Physician/Medical

Completed by

Be

Certification: To

Medical

the burial-transit and physician requires that the death certificate be as use for ed by the a detached f signed to page 2 should certificate Physician: funeral director, After this Hospital or Attending

death.

within 24 hours a er deall To the Funeral Director:

To the

filled in by

completely

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2XN0 1 🔲 Yes Inpatient 2 ER/Outpatient 3 DOA Date of Injury (Month, Day Year) Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 ☐ Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

	29a. Certifier (Check only one)			ertifyi edica	
ľ	29b. Signature and	title	of	certifie	ər

Manica

1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

edical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

MEDICAL DOCTOR

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hospital 400 wolfe St.

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Month **Physician** MARY ELOISE BAKER OCT. 3, 2007 4:20 Р /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SAINT JOSEPH MEDICAL CENTER TOWSON BALTIMORE 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Min. Months 1 □ M 2 🗙 F 217-36-4232 69 Director 2/28/1937 PENNSYLVANIA Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10b. County 10d. Inside City Limits ns 23a or 28a-f show must be notified at CARROLL 1 ☐ Yes 2 X No Director MD WESTMINSTER 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 21158 4380 OLD HANOVER RD. USA death v Funeral 'natural", or items 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married 1 ☐ Yes 2 💆 No Specify: Specify: WHITE ģ 3 Widowed 4 Divorced Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HOUSEWIFE HOME MAKER 10 jes 1 and 2 should be filed of Health and Mental Hygin If item 27 is marked other or other traumatic event, the other 1 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be JESSE N. SANDERS REBA M. LOCHBAUM 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2
Tent of Health ar
It if item 27 is 1 JAMES BAKER, SR. -HUSBAND 4380 OLD HANOVER RD., WESTMINSTER, MD 21158 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 15 Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any Injury or once, PLEASANT VALLEY CEM.10/7/07 PLEASANT VALLEY, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility FLETCHER FUNERAL HOME, P.A. Service Licensee 254 E. MAIN ST., WESTMINSTER, MD 21157 23a. Part1. Enter me disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician a LEFT VENTRICULAR DYSFUNCTION 8 months /Medical Examiner Complication of Arteriolasclerotic 20 years if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Cardiac Disease 60 years burial-tran Due to (or as a consequence of) pe Physician/Medical Rheumatic Heart Disease the phy as 1 IF FEMALE: 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 □ Yes 2 1 No Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ sign Chronic Renal Insufficiency 1 Tyes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 autopsy perform certificate Physician: 25. Was case referred to medical Certification: To Be 26. Place of Death (Check only one examiner' 1 Yes 2 No spital: 1 Inpatient 28a. Date of Injury Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural
2 Accident (Month, Day Year) Injury 5 | Pending death. investigation 1 ☐ Yes 2 ☐ No after death the 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide ö 29a. Certifier X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

Division or Vital Records. within 24 hours a

To the Funeral I

completely filled

P.O. P

Saltimore, Maryland 21215-0036

State Registrar

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SELL M.D. 7601 OSLER DRIVE TOWSON, MARYLAND 21204 JEFFREY EDWARD 31. Date filed (Month, Day, Year) OCT 0 9 2007

29c. License number D38570 29d Date signed (Month, Day, Year)

07-07531 William Breece Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

2007 32134 State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1- For State Reg. No Registrar Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ 0345 hrs **Medical Examiner** September 26, 2007 William Breece 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Mercy Medical Center 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or unk If Under 24Hrs. 7. Age (In yrs. last birthday) If Under 1 Year 5. Social Security Number unk 6. Sex **Funeral** Months Days Hours Min May 22, 1947 Director 60 Country) Yrs. 1X M 2 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County 1 X Yes 2 No Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once. Baltimore MD Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21202 USA 954 Forrest Street 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Funeral unk 12. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. unk Armed Forces? 1 Never Married 2 Married Yes Yes, Give Yea Yes 2 X No specify. Specify: white Divorced Widowed 4 ş 16a. Decedent's Usual Occupation (Give kind of work done unk 16b. Kind of Business/Industry unk 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) unk unk 18. Mother's Name (First, Middle, Maiden Surname) unk unk 17, Father's Name (First, Middle, Last) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print ) 21201 111 Penn Street Baltimore, MD O.C.M.E. 20c. Location - City or Town. State 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition crematory or other place) Burial 2 Cremation 3 Removal from State Donation 5 X Other Specify State and Address of Facility and 655 W. Baltimore Street 21. Sign ture of Junear Strice Licensee Director MD Baltimore, ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval 23a, Part I. Enter the disease, or complica Physician Between Onset and failure. List only one cause on each line Death Medical a. Asphyxia Immediate Lause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): b. Hanging Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examiner cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit The law requires that the death certificate be executed Physician/Medical AMENDED UNPENDED attending physician or use as the burial -Division of Vital Records, P.O. Box 68760, 23d. Date of delivery 23c. If yes, outcome of pregnancy IF FEMALE 23b. Was decedent pregnant in the Year 3 Ectopic pregnancy Month Day Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? signed by t be detache contributing to death but not resulting in the underlying cause given in Part I. Part II. Other significant conditions à Yes 2 ✔ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an certificate has been prior to completion of cause of autopsy performed? death? ~ Yes No ✓ Yes 2 26.Place of Death (Check only one) : Hospital or Attending Physician: 24 hours after death.

5 Funeral Director: After this certifietely filled in by the funeral director, 25. Was case referred to medica Be examiner? Hospital: Nursing Home 5 Residence 6 Other Inpatient 2 V ER/Outpatient 3 1 V Yes 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) Sep 25, 2007 28c. Injury at Work? 28b. Time of Injury 27. Manner of Death Subject found hanging Certification: 0000 hrs Natural Yes 2 V No Pending 2 Investigation Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 V Suicide Could not be or Town, State) 954 Forrest Street, Baltimore, MD determined (Specify) Jail/Penal Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the 1 and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier O.C.M.E. September 28, 2007 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Ana Rubio MD.

Registrar DI IIVIN 17 Rev 1/2001

**OCME 2006** 

Registrar's Signature 31. Date filed (Month, Day, Year) OCT 0 9

ORIGINAL

Amend Item Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- Registrar Amend 10b, 10d, 10f, perFH, g872, 10/9/07 Certificate of Death

Reg. No 2 1 7 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** /Medical 4a. Facility Name (If not institution, give street and n 4b. City, Town, of ocation of Death Examiner roui If Under 1 Year Birthplace (State or Foreign Country) 5. Social Security Number If Under 24 Hrs Sex 1 ☑ M 2 ☐ F **Funeral** Days "Mn 215-05-3483 87 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at Baltimore 1 X1Y00 2 ▼ No Director MD BALTIMORE 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21208 3004 NORTHBROOK ROAD 21209 permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23s any Injury or other traumatic event, the Medical Examiner must Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No WHITE Specify: Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) PROPRIETOR GROCERY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be PHILIP **BLUMBERG** ANNA UNOBTAINABLE ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State Zin Code)
3004 NORTHBROOK ROAD, BALTIMORE, MD 21289 19a. Informant's Name/Relationship (Type. Print) ETHEL BLUMBERG / WIFE 20b. Place of Disposition (Name of SWINT CHER WOLLINER BENEVOLENT ASSOC. 20c. Location - City or Town, State 20a. Method of Disposition 1 ★ Burial 2 Cremation 3 Removal from State 10/07/2007 4 □ Donation 5 □ Other (Specify) BALTIMORE, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. Mast Cen 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) 10Las Physician /Medical Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2☐ No 24a. Was an autopsy performed' certificate 1∐ Yes 20 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A
completely filled in by the fi 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier DOC52 760 October 04, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Road Randallstown, Md VICA 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar OCT 0 9

### **Physician** BAUMGART SARA /Medical 4b, City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Himore settimo of Birth If Under 1 Year | If Under 24 Hrs. Age (In yrs. last birthday, 6. Sex al Security Number **Funeral** 1 M 2 X F Min (Manth, Day, Year) 03/13/1920 066-40-2925 Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County "natural", or items 23a or 28a-f show dical Examiner must be notified at Director BALTIMORE BALTIMORE MD 10f. Zip Code 10e. Street and Number 21208 3312 NERAK ROAD Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Completed 15. Decedent's Education (Specify only highest grade completed) the M-dical nd Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) OWNER permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important; If Item 27 is marked other any Injury or other traumatic event, is 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be TZIRIL **HERCZBERG** SHIMON 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3312 NERAK ROAD, BALTIMORE, MD JONAS BAUMGART / HUSBAND 20b. Place of Disposition (Name of WOODMOOR HEBREW CONG. 10/07/2007 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licensee 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Malf Ler 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a nsequence of) Examiner schemic Sequentially list conditions, if any, leading to inimediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of Examine The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): O. Box 68760, Completed by Physician/Medical attending p for use as IF FEMALE: 23b. Was decedent pregnant 3 Ectopic pregnancy

1. Decedent's Name (First, Middle, Last)

23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery Year in the past 12 months? Month 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 □Unknown 2 NO 1 □ Yes 24b. Were autopsy findings available prior to completion of cause of autopsy perform death? 2 No 2 🗆 No 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ER/Outpatient 3 DOA 2 No 1 Inpatient 27. Manner of Death Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Injury 5 | Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Gertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

2. Date of Death

4c. County of Death

10g. Citizen of What Country?

16b. Kind of Business/Industry

USA

Black, White, etc

GROCERY

20c. Location - City or Town, State

BALTIMORE, MD

14. Race - American Indian,

N/A

9. Birthplace (State or Foreign

WHITE

Approximate Interval Between Onset and Death

10d. Inside City Limits

1 ☐ Yes 2 🛣 No

POLAND

1/

State Registrar

Be

2

Certification:

Medical

Rherda

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2401 W. Belvedere Ave Ballimore

Division or Vital Records, P.

the Hospital or Attending Physician:

After

within 24 hours after death
To the Funeral Director:
completely filled in by the

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Baltimore, Maryland 21215-0036  pernit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural; or Iteme 23a or 28a-1 show any niury or other traumatic event, the Medical Exercites must be notified at			19a. Informant's Name/Relations  C. Michael Banz								Route Number			
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5-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hygiene. I Health and Mental Hygiene. Item 27 le marked other then "naturel", or Items 23e or 28e-f show other treumatic event. The Medical Exatifizational Examiliary at	by	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ ivorced	Armed Forces? 1 □ Yes 2 No If Yes, Give Year or Dates:		f Yes, specify Cuba 1 ☐ Yes 2 No	n, Mexican, Specify:	Puèrto Rican, etc.)		thite, etc. BLACK
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8760,	cate be executed bhysician and the burial-transit	al Examiner	Sequentially list conditions, "any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a conseque						
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	To the Hos within 24 ho To the Fun completely	Me	29b. Signature and title of certifier			29c. License	number		29d. Date signed (Mo	onth, Day, Year)
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3	50.6		30. Name and address of person who	Mp 1940 V	Y. BA		- 17	BALT	IMORE, N	11 21223
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State of Maryland / Department of Health and Mental Hygiene

			- State Amend #8 &30 Per FH C872 10/09/09/ti	figate of I	Death		No.2007	32139
	Physicia	an	1. Decedent's Name (First, Middle, Last)			Month	Day Year	3. Time of Death
	/Medic	al 🖟	Frankie Clayburne  4a. Facility Name (If not institution, give street and number)  4 Page 14 P	th City Town or	C r Location of Death	ct 1, 2	2007 4c. County of Death	1:15A
	Examin	er						
	Funeral		Social Security Number     6. Sex     7. Age (In yrs. last birthday)	If Under 1 Year	de Grace If Under 24 Hrs.	8. Date of Birth (Month, DV) Ye	Harford 9. Birth	place (State or Foreign
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	land bw It		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Locat	tion				10d. Inside City Limits
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	r 28a	Director	10e. Street and Number	10f. Zip Code		10g.	Citizen of What Cou	ntry?
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	ems ems	Funeral		as Decedent of H	lispanic Origin? (Spec an, Mexican, Puerto F	cify Yes or No-	14. Race - Ameri Black, White	
1215-0036	thin 72 hours after death with the Maryland e. an "natural", or items 23a or 28a-f show Medical Examiner must be notified at	by	1 □ Never Married 2 □ Married 1 □ Yes 2 □ No	□Yes <b>X</b> IXNo				Black
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	and 2 sealth an 127 is i	9	Bennie Clayburne 109 V	ancher	ie Ct.			Md 21078
Baltimore,	Pages 1 and nent of Healt int: If item 2: iry or other:		20a. Method of Disposition  1 □ Burial 2 □ Cremation 3 □ Removal from State  4 □ Donation 5 □ Other (Specify)  20b. Place of Disposition cemetery, crema  Garrison			707	c.Location - City or T vings Mil	
altin	permit. Pages Department of Important: If i any Injury or once,	l ŝ			;		_	neral Home
ñ	an per	(V) (2	23a. Part I. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line.	0 Bela	ir Road	Baltimo	ore, Mary	rland 2120
68760,	Physician /Medical Examiner  as the prival-transit as the prival-t	edical Examiner	Immediate Cause (Final disease or condition resulting in death)  Ecquarkially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):	ice, is (	phal errh 3&(.	osni g	1 Cives	Onset and Death
			IF FEMALE.					
O. Box	The law requires that the death cert ate has been signed by the attending agge 2 should be detached for use a	by Physician/N		Ectopic pregnanc Other (specify)	у		23d. Date of delive Month	very Day Year
٦.	that the post of t	y Ph	Part II. Other significant conditions contributing to death but not resulting in the und	lerlying cause giv	ven in Part I.	23e. Did tobac	cco use contribute to	the cause of death?
g	quires n sign ald be					1 ☐ Yes	2 □ No 3 □ Pro	obably 4  □Unknown
Vital Records, P.O	he taw require s has been sig ge 2 should b	Completed				24a. Was an autopsy performe	prior to o	topsy findings available completion of cause of
g	yslclan; The is certificate hadirector, page		25. Was case referred to medical		26. Place of Death	1	No 1∐Yes	2 No
>	/slcla	To Be	examiner?  1  Yes No Hospital: 1 Inpatient 2 ER/Outpatient	3□ DOA Oth	ner:		ce 6 □Other (Spec	rifu)
on or	Attending Physician; r death. ector: After this certifics by the funeral director, p		27. Manner of Death 1 ★ Natural 5 Pending 28a. Date of Injury (Month, Day Year) 28b. Time of Injury	28c. Inju	ry at 2	28d. Describe how		,
Division or	To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral di	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined 28e. Place of injury - At home, farm, stree building, etc. (Specify)			8f. Location (Stree City or Town, S	et and Number or Ru State)	ral Route Number,
Ω	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in I		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death of	occurred at the ti	ime, date and place,	and due to the cau	se(s) and manner as	stated.
	To the Ho within 24 h To the Fu completely	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or inve	estigation, in my				
	To vit	2	29b. Signature and title of certifier		21779	290	Date signed (Month	0)
	M		30. Name and address of person who completed cause of death (item 23a) (Type, Pr	rint)				
	,		Vijay K. Nellore Bel Air MD 2101	4				
	Sta Regist		Vijay K. Nellore  31. Date filed (Month, Day, Year)  OCT 0 9 2007	narte				

			1 - State Amend #19b I	State of Maryla Per FH G872	nd / Depa 10/12/0	rtment of H	lealth and N Death	lental Hyg	iene g. No. 2007	32140	
	Physici /Medic		Decedent's Name (First, Middle, Last)     Gladys		Coldin	ng	2. Date of Deat Month	Day Year	3. Time of Death		
,	Examir		4a. Facility Name (If not institution, give st			4b. City, Town, or Location of Death			4c. County of Dea	th	
			Beverly Living C  5. Social Security Number 6. Sex		s. last birthday)	Wes	stminste		Carr		
	Funeral Director			M 2[XF 9:		Months Days	Hours Min.	8. Date of Birth (Month, Day,	Year) C	thplace (State or Foreign ountry)  VA	
	D >		Usual Residence of Decedent  10a, State 10b, County	100.0	City, Town or Lo	estice				10d. fnside City Limits	
	Aaryla Fehov	ō	MD NA	100.	*	imore				1X Yes 2 No	
	128a-	Director	10e. Street and Number			10f. Zip Code	***	1	0g. Citizen of What C	ountry?	
	th with	ai D	1019 Rosedale St	reet			21216		U.S.	Α.	
36	permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Depertment of Health and Mental Hygiene. Important: If Item 27 is marked other then "naturel", or Items 23a or 28a-f show vary Injury or other treumatic event, I'm Mealcal Examiner must be notified at ance.	by Funeral	11. Marital Status 1: 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	2. Was Decedent Ever in Armed Forces?  1 Yes 2 No If Yes, Give Year or Dates:	1	Was Decedent of H f Yes, specify Cuba 1 ☐ Yes 🏋 No		ecify Yes or No- Rican, etc.)	14. Race - Am Black, Whi Specify: B	te, etc.	
9200-91212	2 hou	Completed by	15. Decedent's Educ	ation	16a. Dece	dent's Usual Occup	ation	vina	16b. Kind of Business	/Industry	
2	ithin 7	nple	(Specify only highest grade Efementary/Secondary (0-12)	Colfege (1-4or 5+)	life.	DO NOT use retired	1)	ang	n	E -	
2	illed w Hygier ther th	S	12th grade  17. Father's Name (First, Middle, Last)	na	Со	mpanion	18. Mother's Nam	e /First Middle I	Priva	re	
Maryland	d be f ental } ked of	To Be	Zack Pleasant			1 1 1 1 1	Mary Co		valuen sumame,		
a <sub>Z</sub>	shou and M mari	۲	19a. Informant's Name/Relationship (Typ	e, Print)					, City or Town, State,		
Ž,	and 2 eelth a n 27 i		Patricia Blue-Ni		-			and the second second		, Md 21176	
Baltimore,	Peges 1 ment of H ant: If ite ury or oth		20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	moval from State	cemetery, crei	sition (Name of matory or other place Memori	:e)		20c. Location - City o	_	
Balt	Depertit. Depertit importit eny inj		21. Supreture of Funeral Service License	2 Simula	M 4	Name and Address arch F/ 300 Wab	H West ash Ave	, Balti	.more, Md	21215	
	Pnysician	0 0	23a. Pa . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Appropriate Cause (Final								
	/Medical		disasse or condition resulting in death)	Due to (or as a conse		THE POP	0/04	1) co ye	-	Months	
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	nsit	nine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a const	equenda of):						
) -	execu an end rial-tra	Examiner	that initiated events c. resulting in death) Last	Due to (or as a conse	equence of):						
8760,	icete be executed physicien end s the burial-transit	dical	d.								
		•	IF FEMALE: 23	c. If yes, outcome of preg	nancy				23d. Date of de	Nê was	
.О. Вох	The law requires thet the deeth certifi ste has been signed by the ettending page 2 should be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown	1 Live birth 2 Fe 4 Pregnant at time of 9 Unknown	tal death 3	Ectopic pregnancy Other (specify)			Month	Day Year	
Division of Vital Records, P.	w requires thet been signed k should be deta	Be Completed by PI	238. Did tobacco discriminating to death out not resulting in the underlying cause given in Part I.								
Heco	The law require has been bage 2 should							24a. Was a autops perform	med? prior to death?	utopsy findings available completion of cause of	
Ita	Physician: The this certificate har al director, page										
5	Physician: r this certific ral director,	2	1 Yes 2 No	ospital: 1 ☐ Inpatient 2 28a. Date of Injury	ER/Outpatier						
O	ding th. After funer	tion	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	28b. Time o Injury	Wor	yat k? Yes 2 □ No	Infury occurred			
DIVIS	al or Attending after death. I Director: After d in by the fune	Certification:	2 Suicide 3 Suicide 4 Homicide  6 Could not be determined  28e. Pface of finiury - At home, farm, street, factory, office building, etc. (Specify)  28f. Location (Street and Number or R City or Town, State)								
	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the funer	Medical C	29a Certifier 1 Certifying Phys. (Check only one) 2 Medical Examin	cian: To the best of my ker: On the basis of examinand manner stated.	n wledge dust nation and/or in	n occurred at the two vestigation, in my o	na, date and place pinion, death occur	and due to the cred at the time, d	auso(s) and manner a ate and place, and du	s stated e to the cause(s)	
	To th within To th	Me	29b. Signature and title of certifier	29c. License number 29d. Date signed (Month, Da			nth, Day, Year)				
)	1		100	TO DELINE		00	059943		october	815003	
	H		30. Name and address person who cor	npleted cause of death (It	em 23a) (Туре, Трич	Print) Ag. Suit	239 U	estmins	Pr MO	2115)	
	Sta Regist		31. Date filed (Month, Day, Year)	a2. Registrar's Sig	nature	Sis.			1		

lames Coradi, III		S1 I-For State Registrar	tate of Maryland		rtment o <i>tificate o</i>		d Mental		Reg. No.	200	7 32	14
Physician	n/	Decedent's Name (First, Midd	le,Last)			· , ••		2. Date of Dea		Year	3. Time of Death	1
Medical Examin		James		Cc	radi	III		October 7	7, 2007	County of Deat	1148 hrs	
		4a. Facility Name (if not institution 8201 Pulaski Highwa				4b. City, Town, or Rosedale			Ва	ltimore Cou	unty	
Funeral Director		5. Social Security Number 214–86–4162	6. Sex 7. Age	e (In yrs. Ia 46	st birthday) Yr:	If Under 1 Year Months Days		4Hrs. 8. Date of Bi Min. Septemb		Foreig		:k
è	-	Usual Residence of Decedent  10a. State 10b. County		10c. City,	Town or Loca	tion					10d. Inside City	Limits
Maryland 28a-f show any d at once.		Maryland Balti		,	Dunda]						1 Yes 2	ΧNο
larylar	01	10e. Street and Number				10f. Zip Code			10g. Citize	n of What Cou	ntry?	
th the M 23a or 2 notified		8203 Bear Creek				2122				SA		
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland tent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f should it it item 27 is marked other than "natural", or items 23a or 28a-f should it it items 23a or 28a-f should be a controlled at once it items 25a.	Funeral	11. Marital Status  1 Never Married 2 X N	12. Was Decedent Armed Forces? 1 Yes 2			as Decedent of His Yes, specify Cuban		? ( Specify Yes or N uerto Rican, etc.)	0-   14	White, etc.	ican Indian, Black,	4
after c	by F		vorced If Yes, Give Year or Dates:			Yes 2 X No				pecify: Whi		
hours 'natin	eted	15. Decedent's Education (Spe Elementary/Secondary (0-12)				nt's Usual Occupat nost of working life.			16b. Kin	nd of Business/	Industry	
36 hin 72 e. than	pe	12 years	College (1-4 or s	)	Fork	klift Dri	ver		Tra	nsporta	ation	
5-00 ed wit tygien other		17. Father's Name (First, Middle	, Last)					Name (First, Middle,				
21215-0036 Juld be filed within 7 IMental Hygiene. marked other than	å	James E. Corac						s Kozlows				
D 2 should and M 7 is m	- 1	19a. Informant's Name/Relation: Sandra Coradi	ship (Type, Print) Wife			-		r or Rural Route Nu ve, Dunda	-			- 1
e, M and 2 Health item 2 traun	ŀ	20a. Method of Disposition	MITÉ	20b. F	Place of Dispo	sition (Name of cer	metery,	Date		ocation - City or		
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than injury or other traumatic event, the Medical and the American and the Ame		4 Donation 5 Other S	n 3 Removal from Sta	Bay	VIEW (	ther place) Crematory		October 0, 2007	Bal	timore,	MD.	
Balt permit. Departi		21 Sanature of Funeral Service	Licensele	Par	200	Name and Address Onnelly F	uneral	Home Of	Dund	alk, P.	A.	
Physician	$\dashv$	23a. Part I. Enter the disease, o	r complications that caused	the death.	Do not enter	the mode of dying,	rs Poi	nt Road, liac or respiratory ar	Dund rest, shock	<u>alk,MD.</u> k, or heart	Approximate In	
/Medical	-	failure. List only one cause Immediate Cause (Final disease	17. 1	d narc	otic int	oxication					Between Onse Death	
xaminer		or condition resulting in death)	Due to (or as a conse			SOLIE CALCELOAL					1	
	۱.	Sequentially list conditions, if any, leading to immediate	b Due to (or as a conse	equence of	):						-	—
	edical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							··· · ·-		1	
xecuta 1 and - transit	EX.		d		<u> </u>							
iO, e be execut	g	X UNPENDED	#23a,PII,2			E <b>,</b> C872, 10/2	24/07 T	Γ	Land	D. L. M. L. P.		
Sox 6876 death certificate e attending phy I for use as the I	Ž.	IF FEMALE: 23b. Was decedent pregnant in t past 12 months?	the 23c. If yes, outcor	ne of pregr		etal death 3	Ectopic pr	regnancy		Date of deliver Month	ry Day Yea	ar
OX 6 ath cer attendi	Physician/M		4 Pregnant at	time of dea	ath 5 C	other (Specify)						
J. B. the de by the ched f	Ph	Part II. Other significant condi	9 Oliknown	h but not re	sulting in the	underlying cause of	given in Part I	I. 23e. Did	tobacco us	se contribute to	the cause of deat	ath?
Division of Vital Records, P.O. Box 68760, tal or Attending Physician: The law requires that the death certificate be as ther death.  The flaw requires that the death certificate has been signed by the attending physic led in by the funeral director, page 2 should be detached for use as the burner.		Cocaine use							es 2	No 3 Pro	obably 4 🗸 Unkr	nown.
rds, requir	Completed by							24a. Wa	s an		utopsy findings av	
eco he law ite has	g E							perf	ormed?	death?		No
tal Reco	BeC	25. Was case referred to medica						heck only one)				
'Vit	Ë,	examiner?  1 ✓ Yes 2 No	Hospital: 1 Inpatie		ER/Outpatier					ce 6 🗸 Othe	er: Scene	
n of iding Pl		27. Manner of Death  1 Natural 5 Pen	28a. Date of Inju (Month, Day, Y	'ear)	28b. Time of		ryat Work? Yes 2 📆 N	28d. Describe	e now injur	y occurred		
IVISION or Attence after death Director:	<u>icati</u>	Natural 5 Pending Investigation Accident Investigation Investigation St. Part 10/7/2007 Fnd 11:37 am 1 Yes 2 X No unk  28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City								er. City		
Div ital or urs after rrat Dir	Certification:	Suicide 6 X Could not be determined (Specify) found in motel room										
N	Medical C		Physician: To the best of maminer: On the basis of exa	y knowledg	ge, death occu	urred at the time, da		e, and due to the car	use(s) and	manner as sta	ted.	
F M F 8	Me	29b. Signature and title of certific		\ .		29c. Licens			1		onth, Day, Year)	
		tatrii la	renier-t	oll	atro	O.C.	M.E.		Octo	ber 8, 2007 		
4		30. Name and address of person Patricia Aronica-Polla	•		•	111 Penn St	reet, Balti	more, MD 212	01			
Sta	.100	31. Date filed (Month, Day, Year,		r's Signatu	re	K.						
Registr DHMH 17 Rev 1/200		OCT 0-9	2007 Aleena	· S	ORIGINA	A.I.						
DOMEST IT REV 1/200	U I		OCME		OKIGINA	<b>7</b> L						

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

OCT 0 9 2007

2007

OCTOBER

CUMMINGS

MARION

ORIGINAL

Fistrar's Signature

TIMONIUM, MD 21093

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygien 2007

As Service Provided in Control of Service and Control of Service Provided in Control of Servi			For State Registrar		Marylan	d / Depa	artment of F	lealth and Death		Reg. No.	007		
A Facility for extraction. The relations of primery and control of the control of	Physicia	an	1. Decedent's Name (First, Middle,		DΧ				Month	Day		3. Time of Dea	
Mercy Medical Canter   Base   September   Base   September   Sep			4a. Facility Name (If not institution,	<u>~</u> _			4b. City, Town, or	Location of De					
The complete   The	Lxamiii	CI	Mercy Medic	al Canter	2		Baltin	nore					
The state of the s	Funeral		5. Social Security Number		Age (In yrs.					rth ay, Ye <i>ar)</i>	9. Birth Cou	place (State or Fo	
The State   10c. Chy.   10c. C	Director		242-64-1152	- X W 2 - 1	6	4 Yrs.			02/06/	1943	N.	Carolina	
Emerging Contains (19-12)   Costage (1-for 5+)   Dispersion   18 Mother Alline (First, Middle, Last)   Dispersion   Dispersi	land ow	}			10c. City	y, Town or Lo	ecation					10d. Inside City Li	
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Emerging and properties and an expectation of the complete of	tural	edt	15. Decedent	s Education		16a. Dece	dent's Usual Occup	ation					
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FEMALE:   23d. Date of delivery   23d. Date of deliv	te be executed sxiden and solution and burial-transit	ical	Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b	NG as a sunscq	uenec off:	wcer						
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Second of the control of the contr	quires that n signed b uld be deta							en in Part I. のよみ・	23e. Did				
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De Deter Stand (Manufa Cons. Manufa Cons. Manufa Companyor)	5		30. Name and address of person v			n 23a) (Type,		NE	BA T	Man	£ 21	207	
State State 31: Date filed (Month, Day, Tear)  Registrar  OCT 0.9 2007	Sta	te	31. Date filed (Month, Day, Year)	32. eg	istrar's Signa	ature	Our P	MY	21101	( 1004	(		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Registrar Amend 28d, perMD, g872, 10/9/07 TT Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** ockirham Z: 10 A M 2007 16 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Manyland Medical Ba Himore University Ct If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex . Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1₩ 2□F 63 213-42-2619 **Director** Aug. 24, 1944 Maryland Usual Residence of Decedent регтії. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location r 28a-f show notified at 10b. County 10d. Inside City Limits 1 ☐ Yes 2 TXTNo Director Maryland Harford Churchville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ed other than "natural", or items 23a or event, the Medical Examiner must be a 21028 USA 9 Calvary Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 🔯 No If Yes, Give 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Completed by 3 ☐ Widowed 4 ☐ Divorced Year or Dates: White 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Mechanic Automobile 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Bohnson Cockerham Sr. Evelyn Elizabeth Castelow item 27 is marke other traumatic 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Calvary Road, Churchville, MD 21028 Priscilla Cockerham / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State = 5 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Important: If any injury or Hilltop Service Corp. 10-5-07 4 ☐ Donation 5 ☐ Other (Specify) Towson, Maryland 21. Signature of Funeral Service Licensee 22 Name and Address of Facility
McComas Funeral Home, P.A. ussell 1317 Cokesbury Road, Abingdon, MD 21009 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final spiration **Physician** tail disease or condition resulting in death) /Medical Due to (or as a consumence of): Examiner mona EH Sequentially list conditions. in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner death certificate be executed EXAMINER sician and burial-trans Due to (or as a consequence of): Jivision or Vital Records, P.O. Box 68760 physician Physician/Medical APPRIVED attending p IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a 9 Unknown 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 1 Inpatient 2 DER/Outpatient 3 DOA funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred
Fell 8ft. hit left side 28c. Injury at Work? 1 🗌 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident 7/19/2007 12:00 after death Director: 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 ☐ Homicide Hartord County Landfill 3241 Scarbero Kd Street, MD 21154 within 24 hours at To the Funeral D 1 Certifying Physician. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner on the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. сотторетел (Check only 2 Medic onel 29c. License number 29b. Signature and title 29d. Date signed (Month, Day, Year) 19646 Mil 07 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Abraham Himare 22 21201 chacl 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** 2007 5:20 a M Valien Cooke October 6 1 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Charlestown Care Center Baltimore 4 8 1 Catonsville If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Hours Davs 1 🗌 M Months New York 119-16-0547 82 May 14 1925 Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits 1 □Yes 2X No ortant: If item 27 Is marked other than "natural", or items 23a or 28a-f st injury or other traumatic event, the Medical Examiner must be notified Director MD Baltimore Catonsville 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21228 USA 709 Maidenchoice Lane Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race · American Indian, Black, White, etc. 1 | Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 🛣 No Specify: ģ Specify: 3₺ Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Registered Nurse Healthcare and Mental Hygir 18. Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First Middle Last) Be William Judson **Victoria** Swanson ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2
Department of Health at
Important: If item 27 Is
any injury or other trans Catharine Cooke, daughter 47 Church Road, Sherman, CT 06784 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Metro Crematory, Inc. 10/5/2007 Baltimore, MD 21. Signature of Funeral Service Licensee Williams 22 Name and Address of Facility Cremation Society of Maryland, Inc. 299 Frederick Road, Baltimore, MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) discose with gangrene Physician yascular /Medical Due to (or as a consequence of): Examiner vascular complications WITH if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner and Due to (or as a consequence of): Box 68760, physician pe Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) P.0. detached 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, à 2 No 3 Probably Unknown damantio Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an Jas 1□ Yes 2☐ No Division or Vital funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient Other: 1 Yes 2 No 2 ER/Outpatient 3 DOA ို Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Hospital or Attending P 24 hours after death. Funeral Director: After the Certification: 1 Natural 2 Accident 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No the 6 ☐ Could not be 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital within 24 hours a To the Funeral L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) completely and manner stated.

State Registrar 29b. Signature and title of certifier

30. Name and

DHMH 17 Rev 1/2001

dress of person who completed cause of death (Item 23a) (Type, Print)

Corpenter

Registrar's Signature

29c. License number

D30989

711 Majolen Choice Lane Catonsville MD

29d. Date signed (Month, Day, Year)

October 05 ZOUT

		•	State Registrar	(	Certificate of	Death	Reg	, No. 2007	32146
Ċ.	Dhysisi	3	1. Decedent's Name (First, Middle, Last)				Date of Death     Month	Day Year	3. Time of Death
	Physicia /Medic	-	ELIZABETH EDNA CELLIT	TO			OCTOBER	4, 2007	6:50 P.™
	Examin	er	4a. Facility Name (If not institution, give street and nu	mber)	4b. City, Town, o	or Location of Death		4c. County of Death	
× 4		1845	MANOR CARE-RUXTON	7. Ann de une le et high	TOWS		O. Data of Disth	BALTIMOF	
	Funeral		5. Social Security Number 6. Sex 1 ☐ M 2 ☒ F	7. Age (In yrs. last birth	Months Days	Hours Min.	8. Date of Birth (Month, Day, Y	rear) Cou	place (State or Foreign Intry)
	Director		216-16-9679 Usual Residence of Decedent	ره			9/30/192	4 MAF	RYLAND
yland	at		10a. State 10b. County	10c. City, Town	or Location				10d. Inside City Limits
Man	a-f sh ifled	ţo	MD BALTIMORE	LUTHERV	ILLE-TIMON	TUM			1 ∐Yes 2X No
th the	or 28g	Director	10e. Street and Number		10f. Zip Code		100	g. Citizen of What Cou	intry?
th wi	23a c	al [	145 HOLLOWBROOK ROAD		21093			USA	
r dea	ems er mi	Funeral		edent Ever in U.S. prces?	13. Was Decedent of I	Hispanic Origin? (Spe an, Mexican, Puerto I	cify Yes or No- Rican, etc.)	14. Race - Amer Black, White	
ING Z IZIS-UUSO be filed within 72 hours after death with the Maryland	or It		1 Never Married 2 Married 1 Yes	2∑ No ve No	1 ☐ Yes 2 ☐ No	Specify:		Specify:	,
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illed G	Hyg other ent, t		2TH GRADE 17. Father's Name (First, Middle, Last)		III DICEPDICE I	18. Mother's Name	(First, Middle, Ma		00110013
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should	and M Is mar aumat	-	19a. Informant's Name/Relationship (Type. Print)	19b.	Mailing Address (Street			City or Town, State, Z	ip Code)
CI	or Heam 27 is marked other than "natural", or items 23a or 28a-f show them 27 is marked other than "natural", or items 20a or 28a-f show other traumatic event, the Medical Examiner must be notified at		SUSAN M. CELLITTO/DAUGH	TER 14	5 HOLLOWBRO	OOK ROAD	LUTHERVT	LLE-TIMONI	21093
, - S	of He fitem r othe		20a. Method of Disposition	20b. Place of I	Disposition (Name of crematory or other pla	(ce)		c. Location - City or 7	
			1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from 4 ☐ Donation 5 ☐ Other (Specify)	State	CREMATORY.	1	8/2007 0	ATONSVILLE	· MD
Dall	Department Important: I any Injury o once.		21. Signature of Funeral Service Licensee	1.151110	22. Name and Addre				HOME, P.A.
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			2 Ja. P. 11. Ther the disease, or complications hat a shock, or heart failure. List only one cause on a	each line.					Approximate Interval Between
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ysicia	s cerdirect	o Be	examiner? 1 Yes 2 No Hospital: 1	Inpatient 2 ☐ ER/Out	patient 3 DOA Oth			ce 6 Other (Spec	ifu)
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lospi	winning 42 nous and robam.  Of the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit		29a. Certifier (Check only (Check only 1 Medical Examiner: On the base)						
the H	the F	Medical	one) and mar	ner stated.		<u> </u>			
OT.	<b>2</b> 0	2	29b. Signature and title of oditifier	10	29c. Licens	se number	290	Date signed (Month	( 200 7
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	/		WINT COLLY		1 15.000				
_	Sta	to	31. Date filed (Month, Day, Year)	Registrar's Signature	1. 1. 1.				

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onald Coble	State of Maryland / Department		2007 3214
	1- For State Registrar Certificate	of Death Reg	. No.
Physician/	Decedent's Name (First, Middle,Last)	2. Date of Death Month	3. Time of Death
ledical Examiner	Ronald Coble	Month September	
, <u></u>	4a. Facility Name (if not institution, give street and number) 1527 Nova Ave.	4b. City, Town, or Location of Death  Capitol Heights	4c. County of Death Prince George's
Funeral	5. Social Security Number unk 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24Hrs. 8. Date of Birth	(MM/DD/YYYY) 9. Birthplace (State or unk
Director		Months Days Hours Min.	Foreign
	Usual Residence of Decedent	Yrs. Jan 22	, 1952 (300,000)
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<u> </u>	MD Prince George's Capitol	Heights	1 Yes 2 X No
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AD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Méntal Hygiene. 27 is marked other than "natural", or items 23a or 23a-f she matic event, the Medical Examiner must be notified at once To Be Completed by Funeral Director	1527 Nova Avenue	20743	USA
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or items 23	1 Never Married 2 Married Armed Forces? unk	If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	White, etc.
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5-0036 led within 72 Hygiene. tother than 'he Medical	unk unk		
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ID 21215-0036 should be filed within 72 and Mental Hygiene. 77 is marked other man natic event, the Medical To Be Comple		iling Address (Street and Number or Rural Route Number	
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E E E	1 Burial 2 Cremation 3 Removal from State crematory or		
Pages 1 ment of F tant: If i	4 Donation 5 X Other Specify: in State		
Baltimore, permit, Pages 1 ar Department of He Important: If ite	21. agreeture of Funeral Service License. Ronald S. Vad- Director S.	2. Name and Address of Facility tate Anatomy Board 655 W.	Baltimore Street
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Physician /Medical	failure. List only one cause on each line.	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Between Onset and Death
vaminer	Immediate Cause (Final disease or condition resulting in death)  Atherosclerotic cardio  Due to (or as a consequence of):	vascular disease	333
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led Insit	(Disease or injury that initiated C.		
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	X UNPENDED	10/11 /07 mm	ý
Box 68760, e death certificate be ex the attending physician and for use as the burial hysician/Medic	#23a,PII,2/,perME,g872 IF FEMALE: 23c. If yes, outcome of pregnancy	, 10/11/0/ 11	23d, Date of delivery
S87 ertific ling p as th	23b. Was decedent pregnant in the past 12 months?	Fetal death 3 Ectopic pregnancy	Month Day Year
OX (eath ce ath ce attenction use	Pregnant at time of death 5	Other (Specify)	_
D. Bc tr the dea by the a ached fo	Part II. Other significant conditions contributing to death but not resulting in the	ne underlying cause given in Part I 23e Did to	bacco use contribute to the cause of death?
ires that the cases signed by the local detached day Phy		, 3	2 No 3 Probably 4 ✔ Unknown
ls, l	Chronic alcoholism	24a. Was a	
Cords, law requir has been s 2 should		autops	prior to completion of cause of
Records, The law requires ficate has been sig , page 2 should be Completed		1 ✓ Yes 2	med? death? 2 No 1 ✔ Yes 2 No
Vital Recysician: The his certificate director, page	25. Was case referred to medical examiner?	26.Place of Death (Check only one)	
F Vita	1 ✓ Yes 2 No Trospital 1 Inpatient 2 ER/Outpati		Residence 6 V Other: Scene
Division of Vital Records, tal or Attending Physician: The law require rs after death.  al Director: After this certificate has been sited in by the funeral director, page 2 should bertification: To Be Completed	27. Manner of Death 1 X Natural 5 Panding (Month, Day, Year) 28b. Time		ow injury occurred
ion ttend death. ttor: / the d	2 Accident Investigation	1 Yes 2 No	<u></u>
ivisi or At after d Direct lin by	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, s	street, factory, office building, etc. 28f. Location (S or Town, Si	treet and Number or Rural Route Number, City (ate)
Division o spital or Attending rours after death. neral Director: Aft filled in by the func Certification:	4 Homicide determined (Specify)		
	29a. Certifier (Check only 1 Certifying Physician: To the best of my knowledge, death or one) Wedical Examiner; On the basis of examination and/or invest		
To the Ho within 24 I To the Fu Completely	and manner stated.		
Σ	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
	Jan Jeg war,	O.C.M.E.	September 24, 2007
	30. Name and address of person who completed cause of death (Item 23a)  Taska Greenberg MD Assistant Medical Examiner 1:	11 Penn Street Baltimore MD 21201	

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

		1- For State Certificate of Death Registrar	Reg. No		321
Physicia	an/	1. Decedent's Name (First, Middle,Last)	Date of Death  Month Day	Year 061	of Death 8 <b>hr</b> s
Exami	_	Damon Coleman (4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death	October 6, 200	c. County of Death	
		Johns Hopkins Hospital Baltimore			
uneral				M/DD/YYYY) 9. Birthplace ( Foreign	State or
irector		218-86-5318   1   X   M   2   F   35   Yrs.   Months   Days   Hours   Min.	Feb. 14, 19	972 Country)	MD
		Usual Residence of Decedent		10d In	side City Limi
w any		10a. State 10b. County 10c. City, Town or Location Baltimore			Yes 2
Maryland 28a-f show any d at once.	tor	10e. Street and Number 10f. Zip Code	10g. C	itizen of What Country?	
or 28; fed a	Director	2701 E. Hoffman Street 21213		USA	
permit. Pages I and 2 should be filed within 72 hours atter death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho Important: If item 27 is marked other than "natural", or items 23a nor 28a-f sho Injury or other traumatic event, the Medical Examiner must be notified at once.		11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Spec		14. Race - American Indi	an, Black,
r item	Funeral	1 X Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto Ri	ican, etc.)	White, etc.  African Americ	ran
affer al", o	by F	3 Wildowed 4 Divorced If Yes, Give Year 1 Yes 2 X No specify:	Tio	Specify:	
natur Exam	ed t	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4 or 5+)  16a. Decedent's Usual Occupation (Give kind of wording most of working life. DO NOT use retired during most of working life.		. Kind of Business/Industry	
in 72 han " dical	plet	Elementary/Secondary (0-12) College (1-4 or 5+)  12 4 entreprenuer		self-employed	
d with	Completed	17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Last)			
ntal H	Be (	Leon Coleman, Sr.	Diane Wa		
hould nd Mei is mai	70	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Ru			de)
alth a m 27 raum		Tinika Walters Coleman / Wife 2701 E. Hoffman Street; Bal 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery.		c. Location - City or Town,	State
of He of He Her t		1 XXBurial 2 Cremation 3 Removal from State crematory or other place)	0./0007		
t. Pag tment rlant: y or o	l k			ndallstown, Mar 1 Home, P.A.	yland_
permi Depar Impo Injur	m	638 N. Gilmor Street;	•	•	7
ysician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or a	respiratory arrest, s	shock, or heart Appr	oximate Inte
Medical	W 3	failure. List only one cause on each line.  Immediate Cause (Final disease a. Multiple Gunshot Wounds			Death
aminer		or condition resulting in death)  Due to (or as a consequence of):			
	ı.	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):			
	nine	cause. Enter Underlying Cause			
ed 1sit	Examiner	events resulting in death) Last Due to (or as a consequence or):			
executed an and al - transit	cal	d. UNPENDED AMENDED			
cate be ex physician he burial	Medical	IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date of delivery	
ertifica ding p e as th		23b. Was decedent pregnant in the past 12 months?	псу	Month Day	Year
leath certific e attending   for use as t	sici	4 Pregnant at time of death 5 Other (Specify)  1 Yes 2 No 9 Unknown g Unknown			
that the de ned by the detached f	l E	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		co use contribute to the ca	
es tha signed be det	o o		1 Yes 2	No 3 Probably	4 Unkno
w requires that as been signed b should be deta	Completed		24a. Was an autopsy	24b. Were autopsy prior to comple	findings ava tion of caus
ne law te has ge 2 s	_		performe 1 ✓ Yes 2		2 N
ysician: The l his certificate l director, page	ပြ	25. Was case referred to medical	only one)		
ing Physician: The law After this certificate has uneral director, page 2 s		examiner?  1 Ves 2 No  Hospital: 1 Inpatient 2 VER/Outpatient 3 DOA  Other: 4 Nursing		sidence 6 Other:	
ling Ph After t funeral			28d. Describe how Subject shot	injury occurred	
E, A	isti	1 Natural 5 Pending   FOUND: 1 Yes 2 ✔ No Oct 6, 2007   O	20f Location (Stre	et and Number or Rural Ro	ute Number
ttendin death ctor: At y the fun	11.9	3 Suicide 6 Could not be determined determined (Specify) Playground	or Town, State 1400 May Court,	2)	ate Hambon
l or Attendin after death. Director: At d in by the fun	Ιŧ				
ospital or Attendin hours after death. uneral Director: At y filled in by the fun	Certification:	1/98. Lettillet	due to the cause(s		
the Hospital or Attendin, hin 24 hours after death. the Funeral Director: At apletely filled in by the fun	lical Certif	1/98. Lettillet	due to the cause(s at the time, date and	d place, and due to the cau	se(s)
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the fineral director, page 2 should be detached for use as the burial - trans	Medical Certif	1/98. Lettillet	t the time, date and	d place, and due to the cause 9d. Date signed (Month, D	
To the Hospital or Attendin within 24 hours after death.  To the Funeral Director: At completely filled in by the fun	Medical Certif	Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and (Check only one)  2  Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred a and manner stated.	at the time, date and	d place, and due to the cau	
To the Hospital or Attending within 24 hours after death.  To the Funeral Director: At completely filled in by the fun	Medical Certif	29b. Signature and title of certifier  29b. Signature and title of certifier  29c. License number  O.C.M.E.  30. Name and address of person who completed cause of death (Item 23a)	at the time, date and	d place, and due to the cau-	
To the Hospital or Attendin Within 24 hours after death. To the Funeral Director: An completely filled in by the fou	Medical Certif	29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and (Check only one) 2 ✓ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred a and manner stated.  29b. Signature and title of certifier  29c. License number  O.C.M.E.	at the time, date and	d place, and due to the cau-	

DHMH 17 Rev 1/2001 OCME 2006 OCME

ORIGINAL

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Date of Death Month 1. Decedent's Name (First, Middle, Last) **ALEXANDER** COHEN OCTOBER 1 2007 8:15P 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death MILFORD MANOR NURSING HOME BALTIMORE BALTIMORE If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Months 1 X M 2 □ F 090-12-7224 94 02/15/1913 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 □Yes 2 No BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4204 OLD MILFORD MILL ROAD 21208 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 14. Bace - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 ☐ Never Married 2 Married WHITE 1 ☐ Yes 2 🛣 No Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) MACHINIST/TOOLMAKER MACK TRUCKS 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) LOUIS COHEN SARAH APPLE 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21208 ANN COHEN / WIFE 4204 OLD MILFORD MILL ROAD, BALTIMORE, MD 20b. Place of Disposition (Name of CHEB), CANAL PARK 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10/05/2007 REISTERSTOWN, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility SOL LEVINSON & BROS., INC. REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part/ Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or yeart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9☐Unknowr 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of 24a. Was an

Physician /Medical Examiner

**Physician** 

/Medical

10a, State

MD

Director

by Funeral

Completed

Be

2

Examiner

**Funeral** 

Director

ral", or items 23a Examiner must b

"natural",

Health and Mental Hygiene. tem 27 Is marked other than other traumatic event, the M

permit. Pages of Pepartment of Financial III III and Injury or of once.

er than "natur, the Medical E

the Maryland t be notified at

Pages 1 and 2 should be filed within 72 hours after death

Baltimore, Maryland 21215-0036

Examin Physician/Medical þ Be Completed

IF FEMALE:

To the Hospital or Attending Physician: The law requires that the death certificate be executed physician are the burial-t as attending p signed by the a has certificate ha Certification: To After this death. within 24 hours after death

To the Funeral Director:
completely filled in by the

Division or Vital Records, P.O. Box 68760

Medical

State

Registrar

4 Homicide 29a. Certifier (Check only one)

25. Was case referred to medical

1 ☐ Yes 2 No

27. Manner of Death

Natural

3 ☐ Suicide

Accident

6 Could not be determined

5 Pending investigation Place of injury - At building etc (Spe

1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Injury

At home, farm, street, factory, office Specify)

Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28c. Injury af Work? 1 ☐ Yes 2 ☐ No

26. Place of Death (Check only one)

28d. Describe how injury occurred

autopsy performe

1☐ Yes 2☐No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Hedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certified 29c. License number

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year) OCT 0 32. Registrar's Signature

death? 1 ∐ Yes

2 □ No

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

1- State Amend #1&17 Per FH G872 10/09/07/Jh
Reg. No. Dargan Schelia 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month O Day Yea **Physician** 830 A M 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Gan If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country)
 Alto 7. Age (In yrs. last birthday) **Funeral** 62 1 □ M 2 💢 F Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location
Baltimore 10a. State 10b. County 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at MD 1XYes 2 □ No Funeral Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Gan 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: Black Be Completed by 3 ☐ Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) State of Maryland Dept. of Social Swas Elementary/Secondary (9-12) College (1-4or 5+) Social Morker 17. Father's Name (First, Middle, Last) WIK 18. Mother's Name (First, Middle, Maiden Surname) Mary Ann Taylor ို 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) View Avenue 4707 Valley Arnitra Jone Balto. MD 21206 20b. Place of Disposition (Name of cemetery, crematory or other 20a. Method of Disposition 20c. Location - City or Town, State 1 ■ Burial 2 □ Cremation 3 □ Removal from State Hill Cemetery 09/29/2067 Baltimore, MD Cedar 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of acility Vaugnn C. Greene Funeral STVCS Baltimore MD 2/2/2 Road 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Myocardia Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner The law requires that the death certificate be executed the burial-transit and Due to (or as a consequence of): physician IF FEMALE: 23c. If yes, outcome pf pregnancy 1 □Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 Other (specify) ed by the a detached f 9 Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an certificate has autopsy Physician: 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 ☐ Inpatient After this 27. Manner of Feath 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 1 Natural
2 □ Accident 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director; A completely filled in by the fi 6 Could not be determined 3 Suicide

Registrar

4 Homicide

29b. Signature and title of certifier

Kichard Walsh

31. Date filed (Month, Day, Year)

OCT 0 9

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Wilkens

32. Registrar's Signature

29a. Certifier (Check only one)

Maryland 21215-0036

Baltimore,

Division or Vital Records, P.O. Box 68760,

1/ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D38662

Baltimore, Maryland 21229

28f. Location (Street and Number or Rural Route Number, City or Town, State)

9/26/0

29d. Date signed (Month, Day, Year)

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2007

			For State Registrar	State of Ivia	, y laire		tificate				Reg. No	/ 1111	7 32151
Ì	Physicia	an	1. Decedent's Name (First, Middle, L	ast)			1.	. /		2. Date of De Month	Da		3. Time of Death
	/Medic Examin	al	4a. Facility Name (If not institution, gi	ve street and number)				own, or L	ocation of Death	October		County of Dea	(16:58 A M
•	Examin	er	The Johns Hople	11	tal	1	Balt	mon	re Cit	ly			
Ę,	Funeral		5. Social Security Number 6.		(In yrs. la	st birthday) Yrs.	If Under 1 Months		If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da		9. Bi	rthplace (State or Foreign ountry)
ı	Director		214-79-1224 Usual Residence of Decedent			115.	03_2	25		06 1	1	07	MD
	yland now at		10a. State 10b. County		10c. City,	Town or Loc					-		10d. Inside City Limits
	e Mar 3a-f sl	ctor	MD NA			Balt							1 X Yes 2 No
	death with the Maryland ms 23a or 28a-f show r must be notified at	Funeral Director	10e. Street and Number 2323 Maryland	Λ.ν.Ο.			10f. Zip C		218		10g. Cit	tizen of What C	
	ns 23 must	eral	11. Marital Status	12. Was Decedent E	ver in U.S	. 13. W	as Decede		panic Origin? (Sp. Mexican, Puerto	pecify Yes or No	)-	14. Race - Am	erican Indian,
0000	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	by	1 XNever Married 2 Married 3 Widowed 4 Divorced	Armed Forces?  1  Yes 2 N  If Yes, Give Year or Dates:	0		Yes, specif		Mexican, Puerto Specify:	o Rican, etc.)		Black, Wh Specify:	lite, etc. Black
2-0-1	nin 72 ho rin "natur Medical	Completed	15. Decedent's li (Specify only highest g	Education rade completed) College (1-4or 5-		16a. Decede (Give k life. D	ent's Usual aind of work O NOT use	Occupati done dui retired)	on ring most of work	king	16b. K	ind of Business	s/Industry
7	ed with	Com	N/A	N/A	-/	1	A/N				L .	N/A_	
	be file	To Be (	17. Father's Name (First, Middle, Las M. Dirieh	1)					8. Mother's Nam Oubah			Surname)	
2	should i	To	19a. Informant's Name/Relationship	(Type, Print)		19b. Mailing	Address (		d Number or Ru			or Town, State.	Zip Code)
2	alth ar 27 is		Abdullahi Hass		1								1 21286
ย์	of Hear		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3		20b. Pla	ace of Dispos metery, crem	ition (Name	e of	i	Date		ocation - City o	
Daillino	Pages tment of tant: If it		4Donation 5 ☐ Other (Spec	cify)	King				rk 10/	6/07	Ra	ndalls	town, Md
ם מ	permit. Page Department of Important: If any Injury or once.		21. Signature of Funeral Service Lic	ansee)		22.	Name and			a break	1. ( .	i Δ	Batemorand
	A A		23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that caused	the death.	Do not ente	r the mode	of dying,	such as cardiac	or respiratory	arrest,	sh mue	Approximate Interval Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Intrac									Onset and Death 21 Days
	Examiner		Conventielly list conditions	Hepanin	+ IN	duce	ed 1	hron	nbocyto	реміа			23 Days
	ed sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	6	conseque	4	/	1.5					57 Days
	al-tran	Examiner	that initiated events resulting in death) Last	/ Due to tot as a	Conseque		_						21 Days
00/00	death certificate be executed e attending physician and of for use as the burial-transit			d. Thrombus	sis o-	E Mod	diffie	d Bl	Cahock	Taussig	Shu	int	27 Days
	ertifica ling ph e as th	Medical	IF FEMALE:	00. 1/									
Ö D	w requires that the death cer been signed by the attendir should be detached for use	Physician//	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome p 1 ☐ Live birth 2 4 ☐ Pregnant at	2 🗆 Fetal	death 3 🗌	Ectopic pre-					23d. Date of d Month	elivery Day Year
Ċ	t the d by the ached	hysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□Unknown									
ž T	law requires that the as been signed by th 2 should be detache	by P	Part II. Other significant conditions			1.4		-	0				to the cause of death?
cords	requir	eted		verect lua	Nigra	SITION	111	i iz ea	+ Anteri		Yes 2		Probably 4 Unknown
T T	ding Physician: The law n. After this certificate has t funeral director, page 2 s	Completed	Ebstews ANOM	aly of th	e in	Kisf'12	1 Vail	40		24a. Was auto perf 1 Yes	opsy ormed?	prior to death?	
VIIal	cian: ertifica ector, p	Be C	25. Was case referred to medical examiner?	Hospital:					26. Place of Dea				
0	Physician: r this certific ral director,	. To	1 ☐ Yes 2☐ No  27. Magner of Death	1; Inpatier		R/Outpatient 28b. Time of			4 Li Nursing n	ome 5 ☐ Res 28d. Describe			pecify)
0	Attending r death. ector: After by the fune	tion	1 Natural 5 Pending 2 Accident investigati	(Month, Day	Year)	Injury	М	lc. Injury a Work? 1 ☐ Ye	es 2□No		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	,	
DIVISION	I or Atter after dea Director I in by th	Certification	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine		ry - At hor :. (Specify,	me, farm, stre )	eet, factory,	office		28f. Location City or To	(Street a	nd Number or i	Rural Route Number,
	To the Hospital or Attendin within 24 hours after death.  To the Funeral Director: Aft completely filled in by the fun	Medical C		Physician: To the best of aminer: On the basis of and manner sta	examinati								
	To the To the Comple	Me	29b. Signature and title of certifier	1			29c.	License	number		29d. D.	ate signed (Mo	nth, Day, Year)
i			10125	ps				POC	12580	6	10	01061	2007
	1		30. Name and address of person wh	o completed cause of de	eath (Item	23a) (Type, I	Print)	C- NO	MOINTIL	Was ELE	TOU	PT KILLY	INVISE MATINE
	Sta	ite	31. Date filed (Month, Day, Year)	32. Registra	ar's Signat	ure FUS	1	900	JV UKITI	1100-0	INCO	, porci	12007 12007 1MCKE, MD 21257
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

1- State of Maryland / Department of Health and Mental Hygiene
Per Amend #31 Per DVR G872 10/09/07 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Rosalie T. DiCarlo /Medical 4a. Facility Name (If not institution, give street and number) Town, or Location of Death County of Death Examiner Franklin Square Hmore if Under 1 Year 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Min 1 □ M 2 🕅 F Months Davs Hours Director 219-16-8626 08-10-1923 81 Maryland Usual Residence of Decedent 10c. City, Town or Location 10a. State 10h. County 10d. Inside City Limits r 28a-f show notified at 1 ☐ Yes 2 No Director Maryland Baltimore Parkville 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code a or ns 23a ( must b 8830 Walther Blvd. Apt. 335 U.S.A.
14. Race - American Indian, Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: White Completed by 3 Widowed 4 □ Divorced "natural" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Medical Elementary/Secondary (0-12) College (1-4or 5+) Item 27 Is marked other that other trains other traumatic event, the Balt. City Health dpt. Custodian 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Bellack 2 Helen Dubawich 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health Connie Bowers (Daughter) 19865 Old York Rd Whitehall, MD 21161 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 ortant: If If injury or c 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If any injury or 4 □ Donation 5 □ Other (Specify) Holv Redeemer Cem. 10-10-2007 Baltimore, Maryland 22. Name and Address of Facility Schimunek Funeral Home of Bel Air 21. Signature of Funeral Service Licensee Inc. 610 W. MacPhail Rd Bel Air, MD 21014 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Due to (or as Monsequence of): /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last er as a consequence of) Physician/Medical Examiner The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): physician at the burial Division or Vital Records, P.O. Box 68760, attending ph for use as t IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 ☐ Other (specify) 4☐ Pregnant at time of death signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an was a... autopsy performed vas 2 No page 2 s 1∐ Yes Hospital or Attending Physician: director 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Yes 2 ☐ ER/Outpatient 3 ☑ DOA 1 Inpatient Certification: To funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manyer of Death 28b. Time of 28d. Describe how injury occurred After 5 ☐ Pending investigation Natural Injury ours after death. 1 🗌 Yes 2 🗌 No 2 Accident 6 Could not be 3☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral [ 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) completely and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie Kes 0000 ess of person who completed cause of death (Item 23a) (Type, Print) 30. Name and add Square Drive Bathmore, Md 21237 9000 tranklin arhana 32. Registrar's Signature 31. Date filed (Month, Day, State

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygieney 1 - For State Registrar Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Dorothy 5:20 P M Lillian 7, 2007 Davenport October /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gilchrist Center Towson Baltimore Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year **Funeral** Min 1 □ M 2 X F Months Days Hours 82 Maryland 218-18-0662 February 9,1925 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10h. County r 28a-f show notified at 1 ☐ Yes 2X No Director Maryland Baltimore Dundalk the 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ms 23a or 7 Pages 1 and 2 should be filed within 72 hours after death with 21222 HSA 7544 Westfield Road Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No r than "natural", or items: 14. Race - American Indian 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify Specify: White þ 3 Nidowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Ith and Mental Hygiene.
27 Is marked other than 'r traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) Housewife Own Home 12 years year 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ameilia Mary Mack Ruggerio Joseph Tuder 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
9320 Ramblebrook Road, Baltimore, Maryland 21236 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s Department of Health ar Important: If Item 27 is any Injury or other trau Colin Davenport son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition October 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Dundalk,MD. Oak Lawn Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 10, 2007 21. Signature of Funeral Service Licenses Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, MD. 21222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or heart failure. Let only one cause on each line. Approximate Interval Between Onset and Death iratory arrest Immediate Cause (Final disease or condition resulting in death) **Physician** leave /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician Physician/Medical the attending pl 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 ☐ Other (specify) 4☐Pregnant at time of death been signed by the should be detached 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an s certificate has b irector, page 2 s autopsy performed' or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1160 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ို this within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral 28a. Date of Injury 28b. Time of 27. Manner of Death Medical Certification: 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation (Month, Day Year) Injury 1-Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide the Hospital 1 🖵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N. Charles St. Proto. ml 20 200 in 32. registrar's Signature 31. Date filed (Month, Day, State Registrar DHMH 17 Rev 1/200

**ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Howard Allan Davis 7, 2007 October 9:30 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** 203 Bengies Rd. Middle River Baltimore If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthdav) 8. Date of Birth (Month, Day, Year) 6. Sex **Funeral** Months 1 M 2 □ F Days Hours 57 Director 219 52 6327 Jan. 22, 1950 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City. Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any lujury or other traumatic event, the Medical Examiner must be notified at once. 10a State 10b. County 10d. Inside City Limits 1 ☐ Yes 2√2 No Baltimore Middle River Director Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 203 Bengies Rd. 21220 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 1969/72 Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 🛛 No þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Electrician Steel Mill 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George Martin Davis Sr. Dora Elizabeth Yancev 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carol Davis (Wife) 203 Bengies Rd. Baltimore, Maryland 21220 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 10/8/2007 Bayview Crematory Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Bruzdzinski Funeral Home P.A. 21. Signature/of Funeral Service Licensee olm 1407 Old Eastern Avenue Essex, Maryland 21221 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** months ancreat /Medical Due to (or a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed as the burial-transit Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 5 Other (specify) 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 1∐ Yes 2XNo 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Thesidence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ဥ this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: 5 ☐ Pending investigation Injury 1 X Natural ours after death.

neral Director: A
filled in by the fu 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital c within 24 hours af To the Funeral C completely filled i 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 10-08-2007 isasailain M.D D45530 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9114 Phladelphia road, MD-2123

Suite 208,

ORIGINAL

32. Tegistrar's Signature

DHMH 17 Rev 1/2001

State Registrar S. SIVASALUAM

31. Date filed (Month, Day, Year)

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2007 32155

Jai y	Taylor Deat	1	- For State Constant Contribution Contribution		Reg. N	lo	, 02.0
	Physicia		Registrar 1. Decedent's Name (First, Middle,Last)		Date of Death     Month Day	y Year	3. Time of Death 0849 hrs
	al Examir		Gary T. Deaton		October 6, 20	07	
		4	4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death Elkton		4c. County of Death Cecil	'
			320 North Street Apartment C		. 8. Date of Birth (M		thplace (State or
	Funeral	1	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24Hrs  Months Days Hours Min	- ·	Foreig	
	Director	L	215-90-7309 1 4M 2 F 42 Yr	S.	12-6-1	740	(dray) //(/)
	any		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Loca	ation			10d. Inside City Limits
	<b>*</b> .		MA Peril Elkton	V			1 Yes 2 No
	rylanc ia-f sh it onc	황	10e. Street and Number	10f. Zip Code	10g. (	Citizen of What Cou	ntry?
1	or 28	Director	BOA AL Storat AST C	21921		U.S.A	
-	with t	ᇹ	11. Marital Status 12. Was Decedent Ever in U.S. 13. W	/as Decedent of Hispanic Origin? ( S Yes, specify Cuban, Mexican, Puerto	pecify Yes or No-	14. Race - Amer White, etc.	rican Indian, Black,
$\geq$	leath r iten	Funeral	Never Married 2 Married 1 Yes 2 No	Yes, specify Cuban, Mexican, Puerto	Ricari, etc.)	/1	Lite
	after c	J P	or Dates:	Yes 2 No specify:	140	b, Kind of Business	
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	36 in 72 han " lical 1	Bet	Elementary/Secondary (0-12)	1		Todos	24/
	with grene ther there	Completed	17. Father's Name (First, Middle, Last)	18.Mother's Name	e (First, Middle, Maic	den Surname)	-
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	212 buld b 1 Men s marl ic eve	2		ing Address (Street and Number of	Rural Route Number	, City or Town, Stat	e, Zip Code)
	MD  nd 2 sho alth and m 27 is aumati		DONNA M. Deaton - Nite 320	N. Street, AD	F.C.EIK	Oc. Location - City o	2/92/
	imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. Itant: If item 27 is marked other than "natural", or items 23a or 28a-f she or other traumatic event, the Medical Examiner must be notified at once or other traumatic event, the Medical Examiner.	ı	20a. Method of Disposition  1 Burial 2 Cremation 3 Removal from State  20b. Place of Disportermentary or or crematory or	osition (Name of cemetery, other place)	Date	D. Education - Only o	, Youn, Gate
	Page nent o ant:		4 Donation 5 Other Specify: Ballvicu	U Crematory 10	-13-07	Baltimo	re Ms
	Baltimore, MD 21215-003 permit Pages I and 2 should be filed within Department of Health and Mental Hygiene Important: If item 27 is marked other till injury or other traumatic event, the Med		21. Signature of Funeral Service Licensee 22.	Name and Address of Facility	Bradley-f	7SKON FL	d. 21222
			23a. Part I. Enter the disease, or complications that caused the death. Do not enter	r the mode of dying, such as cardiac	or respiratory arrest,	shock, or heart	Approximate Interval
	Physician 'Medical		failure. List only one cause on each line.				Between Onset and Death
4	ćxaminer		Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):	complicated by dilate	ed carazan,	эраагу	1
			Sequentially list conditions, b				
		ē	if any, leading to immediate Dub to (or at a consequence of)				1 1
	det	Examiner	(Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):				
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	certificate be executed anding physician and use as the burial - transit	Medical	X UNPENDED AMENDED 4.27,28a-f, perME,8	873, 11/8/07 <u>TT</u>		20.50	
	760, icate be physic the bur		IF FEMALE: 23c. If yes, outcome of pregnancy		nancy	23d. Date of delive Month	ery Day Year
	68 certif nding se as	cian	past 12 months?	Fetal death 3 Lectopic pregii Other (Specify)	larioy		,
	Box 687  e death certific  the attending perfect of the artending perfe	Physician/	1 Yes 2 No 9 Unknown g Unknown				
	cords, P.O. Box 687  Iaw requires that the death certific has been signed by the attending p		Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause given in Part I.			to the cause of death?
	ires the signe	d by			24a. Was an		autopsy findings available
	ords w request speed	olete			autopsy	prior to	o completion of cause of
	Reco	Completed			1 Yes 2		
	Division of Vital Records, P.O. tal or Attending Physician: The law requires that the rs after death.  an Director: After this certificate has been signed by led in by the funeral director, page 2 should be detacl	Be C	25. Was case referred to medical examiner?	26.Place of Death (Chec			
	Vit hysical this call dire	To E	1 Yes 2 No Inpatient 2 ER/Outpatie	G.II. 6	sing Home 5 Re	esidence 6 🗸 Ott	ner: Scene
	ion of Virtending Physicath.  tor: After this the funeral dir		27. Manner of Death   28a. Date of Injury (Month, Day,Year)   1   Natural   5   Pending   The   10/6/2007   Find   8	1 Van 2 Who	unk	,,	
	Sior Vttend death. sctor:	cati	2 Accident Investigation Find 10/6/200/ Find 8	:38 am	28f. Location (Str	eet and Number or	Rural Route Number, City
	Division / James all or / Safter / James all Direct of in the	Certification:	3 Suicide 6 A Could not be determined (Specify) found at home	, , , , , , , , , , , , , , , , , , ,	320 North	St. Apt C	Elkton, MD
	Divis Hospital or A 24 hours after Funeral Dire		29a. Certifier 4 Certifier Physician: To the best of my knowledge death or	ccurred at the time, date and place, a	nd due to the cause(	(s) and manner as s	tated.
	Division of Vital Records, P.O. Box To the Hospiral or Attending Physician: The law requires that the death within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the atte completely filled in by the funeral director, page 2 should be detached for u	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation and manner stated.	igation, in my opinion, death occurre	d at the time, date ar	nd place, and due to	the cause(s)
	To viit	Me	29b. Signature and title of certifier	29c. License number	l l	29d. Date signed (I	
			Doma muncenti, MID.	O.C.M.E.		October 7, 200	)7 
	6		30. Name and address of person who completed cause of death (Item 23a)		MD 04001		
	10		Bottila ivit viitoettii, itie	111 Penn Street, Baltimore,	MD 21201		
		tate		The same of the sa			

3. Time of Death

7:05 PM

1 □XYes 2 □ No

21213 Approximate Interval Between Onset and Death

Certificate of Death

**Physician** /Medical

Egze

3

Baltimore, Maryland 21215-0036

death certificate be executed physician and s the burial-trans as the use for certificate has the

Division or Vital Records, P.O. Box 68760,

2. Date of Death 1. Decedent's Name (First, Middle, Last) 2007 OS T. David 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** SINAI HOSPITAL OF BALTIMORE BAITIMORE CITY if Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Birthplace (State or Foreign Country) Funeral 1 M 2 □ F Months 187-16-7272 Director Sept27,1922 Pa Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits show notified at Director MD N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? r items 23a or iner must be r 6701 Park Heights Ave. Apt. 21215 2D U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? ★ Yes 2 □ No If Yes, Give Year or Dates WWII Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, ıral", or item I Examiner r Black, White, etc 1 ☐ Never Married 2 ☐ Married Specify:Black 1 ☐ Yes 2 XNo Completed by Specify: 3 Widowed 4 Divorced "natural", permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natur any Injury or other traumatic event, the Medical once. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th Clerk Post Office 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Davide ပ Mae 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Ricky Nelson/Son Park Heights Ave. Apt2D Balto. MD 21215 sition (Name of Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) GreenmountCrematoryOct9,2007 Baltimore,MD
22. Name and Address of Facility
CALVIN B. SCRUGGS FUNERAL HOME
1412 E. PRESTON ST. BALTO. MD. 21 21. Signature of Euneral Su Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line ath. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final SEPSIS **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examine that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Dav 5 Other (specify) ☐Yes 2☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Respiratory Arrest Diabetes, cerebravascular 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed Asthma To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient ٩ 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? Medical Certification: 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director: ...
completely filled in by the f 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death account of the cause(s) and manner as stated. (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Oct 05, 2007 PAS # 19507 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. BHARAT RATIAN, (Resident) SINAI HOSPITAL OF BALTIMORE

DHMH 17 Rev 1/2001

State Registrar 32. Registrar's Signature

20. Negroot of Disposition (Name) 2 (Country) 1 (1) (1) (1) (1) (1) (1) (1) (1) (1)				1 - State Registrar	Ce	rtificate of	Death	Reg.	ne №2007	32157
45. Courting of Death 30.31 FALLSTAFF ROAD, #105 BALTIMORE  Usual Relations of Death Annual States  100. States and Authority Courting BALTIMORE  101. States and Authority Courting BALTIMORE  102. States and Authority Courting BALTIMORE  103. States and Authority Courting BALTIMORE  104. States and Authority Courting BALTIMORE  105. States and Authority Courting MD 105. S	K.					DORENEEL		Month	Day 2007	
Social Section Number   Section Number	Ç.				number)	T		00,002		11120111
The Country   The Country										
Top, Date   Top, Clince of White County   Top, Clince of White C	9 5			213-12-0300	7. Age (In yrs. last birthday) 86 Yrs.		If Under 24 Hrs. 8 Hours Min.	3. Date of Birth (Month, Day, Ye 11/26/19	9. Birthpi Coun	ace (State or Foreign hy) MD
DORENFELD DORENSELD / WIFE   30.31 FALLSTAFF ROAD, #10.5, BALTIMORE, MD 21209		ryland how at			10c. City, Town or Lo	ocation			1	•
DORENFELD DORENSELD / WIFE   30.31 FALLSTAFF ROAD, #10.5, BALTIMORE, MD 21209		he Ma 8a-f s	ecto		BALTIM					
DORENFELD DORENSELD / WIFE   30.31 FALLSTAFF ROAD, #10.5, BALTIMORE, MD 21209		3a or 2	i Dir		#105		09	10g.		:ry?
DORENFELD DORENSELD / WIFE   30.31 FALLSTAFF ROAD, #10.5, BALTIMORE, MD 21209		r death	nerg	11. Marital Status 12. Was I	Decedent Ever in U.S. 13.	1		fy Yes or No- can, etc.)	14. Race - America	
DORENFELD DORENSELD / WIFE   30.31 FALLSTAFF ROAD, #10.5, BALTIMORE, MD 21209	9036	ours afte ural", or it I Examin	þ	1 ☑ Never Married 2 ② Married 1 ② Yes 3 ☑ Widowed 4 ☑ Divorced Year of	es 2 No WWII Give or Dates: ARMY	1 □ Yes 2 💢 No	Specify:		Specify: WHIT	E
DORENFELD DORENSELD / WIFE   30.31 FALLSTAFF ROAD, #10.5, BALTIMORE, MD 21209	15-	iin 72 h n "natu A dica	plete	(Specify only highest grade complet	ed) (Give	dent's Usual Occup kind of work done DO NOT use retire	oation during most of working d)	161	o. Kind of Business/Ind	ustry
DORENFELD DORENSELD / WIFE   30.31 FALLSTAFF ROAD, #10.5, BALTIMORE, MD 21209	212	ed with giene er tha	Com	12 College	e (1-40r5+)	ESTOR			REAL ESTAT	E
Physician Medical Examiner  Ph	and	be file	Be		DODENEE			First, Middle, Mai	,	
Physician Medical Examiner  Ph	Ž	should ad Mei marke matic	은					Route Number C		
Physician Medical Examiner  Ph		and 2 salth ar			_ I					*
Physician Medical Examiner  Ph	ore,	ges 1 at of He If item or othe		· ·	20h Place of Disno	eition (Name of	Dat			wn, State
Physician Medical Examiner  Ph	Ē	it. Pag irtment irtant: njury	1	4□Donation 5 □ Other (Specify)				2007 B	BALTIMORE,	MD
Physician Medical Examiner    New York   Company   Compa	Ba	perm Depa Impo any l	1	Tate & Den						
Physician (Medical Examiner)    Physician (Medical Examiner)	ı	<u></u>			at caused the death. Do not enton each line	ter the mode of dyir	ng, such as cardiac or	respiratory arrest		Approximate Interval Between
Sequentially list conditions, large light of the la	ı		ľ	disease or condition resulting in death)		samuly	R PAISY			Onset and Death
Due to (or as a consequence of):    The part of the past 12 months?   1	B				for as a consequence of):					
Due to (or as a consequence of):    The part of the past 12 months?   1		p ±	iner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying	to (or as a consequence of):					
Section   Sect	K	xecute and al-trans	xam	that initiated events resulting in death) Last  Cause (Disease or injury that initiated events c.	to (or as a consequence of):			···		
Section   Sect	760	ysician yelolarie e burie	calE	d						
The state of the				IF FFMALE:						
The state of the	<b>8</b> 0	attendi for use	lan/	23b. Was decedent pregnant in the past 12 months?	ve birth 2 ☐ Fetal death 3 ☐		y			
Solution of the control of the contr	o.	t the d	hysic	1 Yes 2 Lino		Other (specify)				
Solution of the control of the contr		es thai gned t	by P	Part II. Other significant conditions contributing t	o death but not resulting in the u	nderlying cause giv	en in Part I.	23e. Did tobac	co use contribute to th	e cause of death?
Solution of the control of the contr	ord	requir	eted				<del></del>	1 Tes	2 No 3 Prob	ably 4 □Unknown
Solution of the control of the contr	Rec	he law e has t	)du					autopsy performed	prior to con death?	npletion of cause of
1   Yes 2   No   No   No   No   No   No   No	<u>ta</u>						26. Place of Death (		No 1 ☐ Yes	2 □ No
28a. Date of Injury Month, Day Year)  28b. Time of Injury M 28c. Injury at Work? 1   Asstrain 2   Accident 3   Suicide 4   Homicide 4   Homicide 4   Homicide 5   Pending Investigation 6   Could not be determined  28e. Place of injury - At home, farm, street, factory, office  28f. Location (Street and Number or Rural Route Number, City or Town, State)  29a. Certifier (Check only one)  29a. Certifier (Check only one)  29b. Signature and title of certifier 29b. Signature and title of certifier 29c. License number 29c. License number 29d. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  State  Begistrar  31. Date filed (Month, Day, Year) 32. Figistrar's Signature 33. Date filed (Month, Day, Year) 34. Date filed (Month, Day, Year) 35. Figistrar's Signature 36   Injury M 28c. Injury at work? 1   Yes 2   No 28d. Describe how injury occurred 28d. Desc		hysici his ce Il direc	0	1 ☐ Yes 2 🕻 No	☐ Inpatient 2 ☐ ER/Outpatier	nt 3□ DOA Oth			e 6 □Other (Specify	')
2   Accident   3   Suicide   4   Homicide   4   Homicide   4   Homicide   5   Suicide   4   Homicide   5   Suicide   4   Homicide   5   Suicide   4   Homicide   5   Suicide   5   Sui	ouc	ding P		1 XNatural 5 □ Pending (A		Wor		d. Describe how i	injury occurred	
by the state of the course of	Visio	Attender death ector:	ificat	3 Suicide 6 Could not be	ace of injury - At home, farm, sti			f. Location (Stree	t and Number or Rura	Route Number,
29a. Certifier (Check only one) 29b. Signature and title of certifier 29b. Signature and address of person who completed cause of death (Item 23a) (Type, Print) 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 283.5 Sm.th. Ave. B-It, mp 21209 31. Date filed (Month, Day, Year) 32. Registrar's Signature and title of CT 1 9 2007		ital or rs afte ral Dir led in	Cert							
29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  State  31. Date filed (Month, Day, Year)  32 Pegistrar's Signature  33. Registrar's Signature  34. Date filed (Month, Day, Year)  35. Registrar's Signature  36. License number  29d. Date signed (Month, Day, Year)  283.5 Sm. th. Auc B. It., M.D. 21209		e Hosp 24 hou e Fune etely fil		(Check only 2 Medical Examiner: On the	ie basis of examination and/or in	h occurred at the tile evestigation, in my o	me, date and place, an opinion, death occurred	d due to the caus d at the time, date	se(s) and manner as st and place, and due to	ated. the cause(s)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  State  Begistrar  31. Date filed (Month, Day, Year)  OCT 0 9 2007  32. Registrar's Signature  OCT 0 9 2007		To the within To the complete	Me							
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  BETH MARUS 2835 Smith Ave Bult, mp 21209  State  Begistrar  31. Date filed (Month, Day, Year)  OCT 0 9 2007 32. Registrar's Signature	)	_		> Roh mm	M.D	). Do	05528	54	Oct 3	2007
State  31. Date filed (Month, Day, Year)  32. Registrar's Signature  Registrar		13		30. Name and address of person who completed of Britannian Research	ause of death (Item 23a) (Type,	Print)	2835 5	noth Ac	re Bult, v	no 21209
		Sta Registr		31. Date filed (Month, Day, Year)  OCT 0 9 2007	Pegistrar's Signature	peri				

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			1 - For State Registrar	State of	Marylar		artment rtificate					leg. No.	007	
	Dharaini		1. Decedent's Name (First, Middle, La	st)							2. Date of Dea Month	ith Day	Yeer	3. Time of Death
	Physici /Medio		Dorothy J. Eve	rett							Octobe		2007	1:10 P M
1	Examir		4a. Facility Name (If not institution, given	e street and nur	nber)		4b. City, T	own, or	Location of	of Death		4c. 0	County of Dea	ath
			11 1st Light	Court					timor					
	Funeral			Sex 1 □ M 2]X] F	7. Age (In yrs.		If Under 1 Months	Year_ Days	If Under Hours	Min.	8. Date of Birth (Month, Day	Year)	0	rthplace (State or Foreign country)
	Director		218-26-9259	ILIM ZBUF	76	Yrs.		•			June 29	, 19	31	Maryland
	pu *		Usual Residence of Decedent  10a. State 10b. County		10c Ci	ty, Town or Lo	cation							10d. Inside City Limits
	sho	5												1∭Yes 2 No
	28a-f	ect	Maryland N/	A			Baltin				T	10a Citiz	en of What C	Country?
	with a or a	Funeral Director					TOT. ZIP		1007			rog. One		
	s 23	eral	11 1st Light Cou		dent Ever in U	18 12	Was Decede		1237	gin2 (Spe	cify Yes or No-	11	U. S.	A . serican Indian,
	itam Itam	Š	11. Marital Status  1 ☐ Never Married 2 ☐ Married	Armed Fo	rces?	J.O. 13.	If Yes, specif	fy Cuba	n, Mexican	i, Puerto F	cify Yes or No- Rican, etc.)		Black, Wh	
36	Ir, or	by F	3 X Widowed 4 ☐ Divorced	If Yes, Giv Year or Da	0		1 🗆 Yes 2	<b>X</b> ) No	Specify:			5	Specify:	White
215-0036	within 72 hours after death with the Maryland ene. than "neturel", or Itams 23a or 28a-f show the Marifel Exemither, use be mailfied at	ed	15. Decedent's E	ducation		16a. Dece	dent's Usual	Occupa	ition			16b. Kin	d of Busines	s/Industry
15	nin 7	Completed	(Specify only highest gr Elementary/Secondary (0-12)	ade completed) College (1	40151	(Give	kind of work DO NOT use	k done d e retired	lu <i>ring m</i> os. )	t of workin	ig			
212	the did not be the second	E	8	Conege (1	-40( 3+)		Labor	rer				Too	1 & Dy	re
	otha otha	Bec	17. Father's Name (First, Middle, Las	')					18. Mothe	er's Name	(First, Middle,	Maiden S	Gumame)	
2	lenta lenta rked	To B	Anthony Cephalis						Jo	seph	ine Cub	а		
Maryland	shot and N ama	ļ-	19a. Informant's Nama/Relationship	Type, Print)		19b. Mailir	ng Address (	(Street a	ind Numbe	er or Rura	Route Numbe	r, City or	Town, State,	Zip Code)
	alth alth 27 is		Donna Willis (Da	ughter)		11	1st Li	ight	Cour	ct, B	altimor	e, M	arylar	nd 21237
ē,	item item		20a. Method of Disposition			Place of Dispo	sition (Name	e of her place	9)	D	ate	20c. Loc	ation - City o	r Town, Slate
E	nit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar narment of Health and Mental Hygiene. ortant: If item 27 is marked other than "natural", or Itams 23a or 28a-f show injury or other traumatic event, the Medical Examinational De notified at a.		1 ☑ Burial 2 ☐ Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Speci		State	klawn (	,			0/08/	/2007	Bal:	timore	, Maryland
Baltimore,	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Manary injury or other traumatic event, the Manary injury or other traumatic event, the Manary injury or other traumatic event, the Manary injury or other traumatic event, the Manary injury or other traumatic event, the Manary injury or other traumatic event, the Manary injury or other traumatic event.		21. Signature of Funeral Service Lice	nsee										ome Inc.
m	Depa Impo any ir		160											id 21236
760,	Physician // Medical Examiner	icai Examiner	23a. Pami. Enter the thease, or con shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate and the cause (Disease or injury that initiated events resulting in death) Last	a. Due to (	ach line.	quence of):								Interval Batween Onset and Death
P.O. Box 68	w requires that the death certificate s been signed by the attending phy should be detached for use as the	by Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 menths? 1 Yes 2 Who 9 Unknown  Part II. Other significant conditions	4□Pregn 9□Unkno	irth 2 ☐ Feta ant at time of o own	el death 3 [ death 5 [	Ectopic pre Other (spe	ocify)	en in Part I.		23e. Did to		3d. Date of do Month e contribute	elivery Day Year to the cause of death?
ğ	quire an sig	edt									1 🗆 Y	es 25	Mo 3□F	Probably 4 Unknown
I Records,	The law ate has b page 2 sl	Completed									24a. Was autop perfor	sy med?	24b. Were a prior to death?	
Vital	ding Physician: Th h. After this certificate funeral director, pag	Be	25. Was case referred to medical examiner?	Haradan I.		-		0.1		of Death	(Check only o	ne)		
of	hysi this c	P	1 ☐ Yes 2 ☐ No			ER/Outpatier	-	-	4 🗆 140		ne 5 Nesid			ecify)
ū	on (fter	on:	27. Manner of Death 1 SNatural 5 ☐ Pending		of Injury h, Day Year)	28b. Time o Injury		le. Injury Work			8d. Describe h	ow injury	occurred	
sio	Attending r death. sctor: After by the fune	cat	2 Accident investigation 3 Suicide 6 Could not to				М		res 2 🗌		04 h	```	A4	Down I Charles Aboundance
Division	or At fter o Jirec in by	Certification:	4 Homicide determined	buildi	of injury - At r ng, etc. (Speci	nome, farm, sti ify)	eet, factory,	office		4	City or Tou		Number or r	Ru <i>ral R</i> oute Number,
	To the Hospital or Attandi within 24 hours after death To the Funeral Director: A completely filled in by the fo	Medical Ce	29a. Certifier 1 Certifying P	miner: On the ba	best of my kn asis of examinater stated.	owledge, deat ation and/or in	h occurred a vestigation,	it the tim	e, date an pinion, dea	id place, a	nd due to the d at the time, d	ause(s) a	and manner a	as stated. ue to the cause(s)
	ithin in the or the or the or the	Mec	29b. Signature and title of certifier	and mam			29c.	License	number			29d. Date	signed (Mor	nth, Day, Year)
	To Too		1 1 1				0	455	376				1511	7
	1		1 Justica	completed as	a of death (II-	m 23a) /T		100	, ( )			1 (	7 ) (	7
	1	-	30. Name and address of person who	completed caus	e or death (Ite	n pholl		1,	Res	Itin	10xe, 1	nn	212	3 6
	- 04	10	31. Date filed (Month, Day, Year)	32/A	egistrar's Sign	afinte	10100	1	y de la	71117	0.010	, 40	×1~.	<i>/</i> 100
	Sta Registi		OCT 0 9 2	007	William &	G 90								

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

OCT 0 9 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 10f, 19b per fh 9872 10-9-07 vt State of Maryland / Department of Health and Mental Hygien 7 1 - For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 2004 /Medical 4b. City, Town, or Location of Death County of Death Examiner Ham If Under 24 Hrs. (In yrs. last birthday Birthplace (State or Foreign Country) Age **Funeral** Days Months Hours 218-05-6503 15€M 2□F 8 Director Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits or 28a-f show The Medical Examiner must be notified at 1 Yes 2 No MD Funeral Director Hmore 10e. Street and Number 21213 10g. Citizen of What Country? 10f Zin Code venue items 23a 12. Was Decedent Ever in U.S. Amed Forces? 1 M Yes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 "naturel", or 1 ☐ Yes 2 X No Specify. Black þ 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) ongshoreman 6th 17. Father's Name (First, Middle, 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be nordon bessie rarles 19a Informant's Name/Petationship (Typ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If Item 27 is any injury or other trau Balto Grand Dunghter 20b. Place of Disposition (Name of Cameters, crematory prother) 20a. Method of Disposition

1 Burial 2 Cremation Date 20c. Location - City or Town, State 3 Removal from State 101 \*4 □ Donation 5 □ Other (Specify) POOR 21. Signature of Funeral Service Licensee Funeral Services 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death EREBRO VASCULAR Immediate Cause (Final disease or condition resulting in death) ATHEROSCHEROTIC **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine To the Hospital or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760. Physician/Medicai the ed by the attending detached for use as 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Dav Year 4☐Pregnant at time of death 5 Other (specify) o 9 Unknown 9 Unknown signed by i Records, P. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 Dunknown cate has been signate, page 2 should t 2 🗆 No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? Yes 2 No certificate 1 ☐ Yes Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA ursing Home 5 Residence 6 Other (Specify) this I Diractor: After this d in by the funeral d 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours after To the Funeral Dira Cartifying Physician: To the best of my knowledge, death oncurred at the tinie, date and plane, and due to the cause(s) and mainly as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medicai and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 28532 suell who completed cause of death (Item 23a) (Type, Print) SMITH AVE, SUITE 203 2835 IASNEEM 32 egistrar's Signature 31. Date filed (Month, Day, 0 9 State Registrar

DHMH 17 Rev 1/2001

WILLIAM FORRESTER

Division or Vital Records, P.O. Box 68760,
ital or Attending Physician: The law requires that the death certificate be expected.

Baltimore, Maryland 21215-0036

。 State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

DR. TARIQ MAHMOOD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2300 DULANEY VALLEY RD.

32. Registrar's Signature

29d, Date signed (Month, Day, Year,

TIMONIUM, MD 21093

		•	For State Registrar	State of Marylan		Department of H Certificate of I			eg. No.	07	32162
	Physicia	20	1. Decedent's Name (First, Middle, Last)					2. Date of Deat Month	Day	Year	3. Time of Death
	/Medic		Jeanette S.					October		2007	1:35 P M
	Examin	er	4a. Fecility Name (If not institution, give			4b. City, Town, or		ith	4c. Count	y of Death	
-			4914 E. Federal 5 5. Social Security Number 6. Sec		last bin		imore	s. 8. Date of Birth		9. Births	place (State or Foreign
Ls	Funeral Director			M 2∏F 93		Yrs. Months Days	Hours Mir		Year)	Pen	nsylvania
\$4.			Usual Residence of Decedent								
arylar	show d.e.t	_	10a. State 10b. County	10c. Cit	y, Tow	n or Location				,	10d. Inside City Limits 1 X Yes 2 □ No
he M	8a-f.	Director	Maryland N/A			Baltimore	9		0g. Citizen of	What Cou	
with t	De n		10e. Street and Number	_		10f. Zip Code	205	•		. S. A	
eath	ns 23	Funeral	4914 E. Federal S	12. Was Decedent Ever in U	S.	13. Was Decedent of H	ispanic Origin? (	Specify Yes or No-	14. Ra	ice - Americ	can Indian,
<b>3-0030</b> 72 hours after death with the Maryland	f Health and Mental Hygiene. item 27 is marked other than "natural", or items 23e or 28e-f show other traumatic event, I're Medical Examiner must be notified at	þ	1 Never Married 2 Married 3 X Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates:		If Yes, specify Cuba 1 ☐ Yes 2 ※ No	in, Mexican, Pue	nto Rican, etc.)	Speci	ack, White, ify: Wh	nite
2 2 2	natura IIcal B	Completed	15. Decedent's Edu (Specify only highest grad	cation	16a.	Decedent's Usual Occup (Give kind of work done	ation	orkina	16b. Kind of E	3usiness/In	idustry
ithin i	al Hygiene. other than "n vent, it a Med	nple	Elementary/Secondary (0-12)	College (1-4or 5+)		life. DO NOT use retired	1)		_		
7 bel	her th		12 17. Father's Name (First, Middle, Last)			Homemak		ame (First, Middle,		n Home	<u>e</u>
	ntal h	Be						ydia Thom		1110)	
_ ≥	and Menta Is marked raumatic ev	2	Charles Smith  19a. Informant's Name/Relationship (T)	pe. Print)	19b	. Mailing Address (Street		<u> </u>		n, State, Ziţ	o Code)
- CI	ealth ar n 27 is ner trau		Geraldine Hockett		49	914 E. Feder	al St.,	Baltimor	e, Mary	yland	
~ עם	f Hea item othe		20a. Method of Disposition	20b. F		Disposition (Name of ry, crematory or other place			20c. Location		own, Stete
aitimor	nt: If		1 X Burial 2 ☐ Cremation 3 ☐ F  `4 ☐ Donation 5 ☐ Other (Specify)	emoval from State		ns of Faith		09/2007	Baltime	ore,	Maryland
	Department of I Important: If its any injury or of once.		21. Signature of Funeral Service Licens	90		22. Name and Addres	ss of Facility S	chimunek :	Funeral	1 Home	e Inc.
			23a. Part1. Enter the disease, or compi shock, or heart failure. List only o	jeations that caused the deat	h. Do i	not enter the mode of dyin	g, such as cardi	ac or respiratory arr	est,		Approximate Interval Between
1	nysician Medical xaminer		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a onsec	luence		2.114 C	occh	37021		2 MECK
		ē	Sequentially list conditions, if any lagging to immediate	Due to for as a consec	uence	of):					
V pg	ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events								
Cate be executed	physician and the burial-transit		resulting in death) Last	Due to (or as a consec	uence	of):					
ate be	nysicia he bu	edicai		J							
E	ing pt		IF FEMALE:								
de de de de de de de de de de de de de d	e atter	Physician/M	23b. Was decedent pregnant in the past 12 months?  1 ☐ Yes 2 ☐ No 9 ☐ Unknown	3c. If yes, outcome of pregnation 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of continuous forms.	death	3 □Ectopic pregnancy 5 □ Other (specify) _				ate of deliv fonth	very Day Year
r jag	been signed by the should be detached		Part II. Other significant conditions co	ntributing to death but not res	sulting is	n the underlying cause giv	en in Part I.	23e. Did to	bacco use cor	ntribute to t	the cause of death?
	n sign	d by	Ceron	ar Arte	50	1 Disea	le	1 □ Y	es 2.⊒No	3 🗆 Pro	bably 4 Unknown
The law requires that the	S C/	Completed	Ato	ay F.	br	Matron		24a. Was a autop: perfor	sy med?	prior to co death?	opsy findings available ompletion of cause of
			25. Was case referred to medical				26 Place of D	1 ☐ Yes eath (Check only or	2 No	1 🗆 Yes	2LI No
VSICI8	s cert direct	To Be	examiner?	Hospital: 1 Inpatient 2	ER/Ou	utpatient 3 DOA Oth	A CONTRACTOR	Home 5 X Resid	7.5	ther (Speci	ify)
on or	h. After th funeral		27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)		Time of 28c. Injury Wor		28d. Describe h			<u> </u>
DIVISION OF VITA To the Hospital or Attanding Physician:	within 24 hours after death.  To the Funeral Director: A completely filled in by the fu	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Speci		arm, street, factory, office		28f. Location (S City or Tow	treet and Num n, State)	nber or Run	ral Route Number,
Hospita	24 hours Funera etely fille	Medical C		sician: To the best of my knoner: On the basis of examinating and manner stated.							
othe	within To the comple	Me	29b. Signature and title of confider	<i>L</i> -	.\	29c. Licens	e number	3 0	29d. Date sign		• '
	, 0		30. Name and address of person who c	ompleted cause of death (Itea	m 23a1	(Type, Print)	3:55	93			.2007
	10		31. Date filed (Month, Day, Year)	12. Registrar's Sign	12	(Type, Print) 4 Mace	Av,	Bakto	1115	2, 21	221
	Sta Registi		OCT 0 9 200	7 Beren D	S. S. S.	GOOD STAN					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2007 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death October 6 2007 **Physician** FRANK ANTHONY FUCILE 6:01 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Greater Baltimore Medical Center Towson

If Under 1 Year If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or roreign) |

Months Days Hours Min. JUNE 8, 1938 | PENNSYLVANIA Towson 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 163-30-2520 69 Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10h. County 10d. Inside City Limits ral", or Items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 ☐ No Director MD BALTIMORE MONKTON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3609 LORD BALTIMORE WAY 21111 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: Specify: WHITE ģ 3 ☐ Widowed 4 ☐ Divorced Baltimore, Maryland 21215-003 "natural", Completed If item 27 is marked other than "nature or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) **EDUCATOR** EDUCATION 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mental DOMINIC FUCILE THERESA FALSETTI 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is m any injury or other traum CAROLYN FUCILE wife 3609 LORD BALTIMORE WAY MONKTON, MD 21111 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ST. JOHN HYDES 10/11/2007 HYDES, MARYLAND 22. Name and Address of Facility HENRY W. 21. Signature of Funeral Service Licensee JENKINS & SONS CO. ONANO 16924 YORK RD. MONKTON, MARYLAND 21111 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Evere acité stenosis /Medical Due to (or as a consequence of): Examiner Renal Failure Clarke an chrauc Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine physician and the burial-transit Myocandial Due to e as a consequence of): Box 68760. Physician/Medical as ed by the attending detached for use as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 5 ☐ Other (specify) P.O. 9 Unknown as been signed by 2 should be detact Part Ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records. 9 4 Unknown Vascular 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has autopsy performe page 2 No Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA P funeral 28b. Time of 28a. Date of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: After 5 Pending investigation 1 Natural 2 Accident (Month, Day Year) Injury To the Hospital or Attendir within 24 hours after death.

To the Funeral Director: All completely filled in by the fu 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Myunt mo D0055301 08 2007 Curi Win

State

Registrar

TOWSON,

State of Maryland / Department of Health and Mental Hygiene

2007 32164

			or State		Certi	ficate of	Death		- 12		Reg. No.		3. Time of Death
Physic I Exar		1. [	Decedent's Name (First, Middle Krystah Fay	<del>re-Flanner</del>		h Fave F	lannery			Date of Dea Month October (	Day 6, 2007	Year	0217 hrs
		4a.	Facility Name (if not institution	on, give street and nu	umber)	4	<ul><li>b. City, Town</li><li>Arnold</li></ul>	, or Location	of Death			e Arund	
			557 Broadwater Road		1 (In In	Listh do. V	If Under 1	Vear If Lind	er 24Hrs.	8. Date of B	irth(MM/DD	YYYY) g.	Birthplace (State or
Funera Directo			Social Security Number 220–27–2895	6. Sex	7. Age (In yrs. last		Months	Days Hours		1	5/1982	Fo	oreign Country Maryland
		_	ual Residence of Decedent		Ino City T	own or Locati	on						10d. Inside City Limits
w any		10a	a. State 10b. County				J.,						1 Yes 2 X No
Aaryland 28a-f show	tor	<u> </u>		Arundel	Arno	1a	10f. Zip Co	de		Т	10g. Citizer	of What (	Country?
Mary	Director	100	e. Street and Number	-l- Dood				012			ī	JSA	
th the 23a o	91 <b>-</b>		848 Mill Cree		ecedent Ever in U.S	. 13. Wa	s Decedent o	f Hispanic Or	igin? ( Spe	ecify Yes or N		. Race - A	merican Indian, Black,
ath wi	Funeral	1	X Never Married 2 N	Married Armed I	Forces?	If Y	es, specify C	uban, Mexica	n, Puerto F	Rican, etc.)		White, et	ic.
ter de				vorced If Yes, Give Ye	2 X No			No specify					White
urs af tural	amhte	?⊢-	5. Decedent's Education (Sp			16a. Deceder	it's Usual Oct	cupation (Give g life. DO NO	e kind of w	ork done ed)	16b. Kin	d of Busine	ess/Industry
72 ho	Medical Exam		Elementary/Secondary (0-12	) College	(1-4 or 5+)		ail Cl					'andl	e Company
5-0036 Led within 7 Hygiene. I other than	Comple		12						er's Name	(First, Middle			e company
21215-0036 and be filed within 72 Mental Hygiene.	e e	>  ''	7. Father's Name (First, Middle							rewer			
2121 ould be fi	ic event,		Brian Flanne:  la. Informant's Name/Relation		<del> </del>	19b. Mailin	g Address (	Street and No	umber or R	tural Route N	lumber, City	or Town, S	State, Zip Code)
MD 21215-0036 ad 2 should be filed within 72 hours after death with the Maryland than Mental Hygiene. m 27 is marked other than "matural", or items 23a or 28a-f sh	matic	- 1	Kara C. Flann		er	P.O.	Box 5	034, 0	cean	City,	MD 21	843	
and 2	tran	20	a. Method of Disposition		20b. P	lace of Dispor	sition (Name ther place)	of cemetery,	Oct	Date 10,			ity or Town, State
Baltimore, MD 21215-003 pernit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiener. In non-tien 1 it item 27 is marked other the	othe		Burial 2 X Cremation 5 Other		Iron State	etro Ci		ry	20	0.7	Bal	timo	re, MD
I <b>ffin</b> nit. P artme	1.y or								U.A		orzorna	Darl	k Funeral Hom
Deg Deg	Í		1. Signat of Funera e id 3a. Part'l. Inter the lisease,	/ Wall	med	$\Delta$	25 Cov	Ritch	ie Hw	V Se	errest shoc	Pari	MD 21146
hysici		16	3a. Part'l. Inter the lisease, failure List only one caus	se yar passar inte.									Between Onset and Death
Medic ∠xamir		Ir	mmediate Cause (Final diseater condition resulting in death)	a Dissemi	inated meth	icillin	<u>resista</u>	nt staph	yloco	ccus au	<del>reus (</del> M	RSA) -	
		l°	r condition resulting in death	Due to (or as	s a consequence of	) intect	ion						
			sequentially list conditions, any, leading to immediate		s a consequence of	:):							
	•	ᄞᆲ	ause. Enter Underlying Caus Disease or injury that initiated	Due to /or a	s a consequence of	f):							
ted	transit	°∣≝	events resulting in death) Las	d.	•								
760, cate be executed	al - tra	/Medical	XUNPENDED	X AMENDS	a,PII,27,pe		3. 11/2	/07 TT/	#1.pe	rME, g87	3, 11/8	/07 TI	1
<b>760,</b> Icate be	the burial -	₩ I	F FEMALE:	23c. If ye	as outcome of pred	nancy					230	. Date of d Month	delivery Day Year
687 ertific			3b. Was decedent pregnant in past 12 months?		e birth egnant at time of de	2	etal death Other (Specia		opic pregn	ancy	- 1	WIGHT	bay (oa.
Box 68 e death certif	e attending	Physician	1 Yes 2 No 9 🗸 I		known	5 <u> </u>	other (Specia	у/					
<b>D. B</b>	by the		Part II. Other significant con	ditions contribution	g to death but not r	esulting in the	underlying o	ause given ir	Part I.				oute to the cause of death?
P.C	ngned oe det	ē l	Cocaine use										Probably 4 Unknown
'ds,	peen s	etec								la	Vas an autopsy	pr	Vere autopsy findings availab rior to completion of cause of
Vital Records, P.O. Box 68' ysician: The law requires that the death certifications of the control of the contr	e has	Completed by									erformed? (es 2 N		eath? ✓ Yes 2 No
_ <b></b>	or, pa	ပ္တို	25. Was case referred to med	dical			2	6.Place of De		only one)			
/ita	his cer direct	) B	examiner? 1 ✓ Yes 2 No_	Hospital:	Inpatient 2	ER/Outpatie				ing Home 5			Other: Scene
INTECTION ON OF VITAL tending Physiciau eath.	ofter t	$\vdash$	27. Manner of Death	28a. D (M	oate of Injury lonth, Day,Year)	28b. Time o	of Injury 2	3c. Injury at V		28d. Desc	ribe how inju	ary occurre	30
On tendir	the fu	at l		Pending nvestigation				1 Yes 2		29f Locat	ion (Street a	nd Numbe	er or Rural Route Number, Ci
Division al or Attendi	Direct in by		3 Suicide 6 C	Could not be 28e. I	Place of Injury - At h	nome, farm, st	reet, factory,	office building	g, etc.		wn, State)	na Hambe	, or regarded the second
Spital Spital	filled	Certification:	4 Homicide	determined (Spec	**		ourrod at the	time date an	d place, ar	nd due to the	cause(s) ar	id manner	as stated.
DIVIS To the Hospital or A	To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached		29a. Certifier 1 Certifying Check only 2 Medical I	g Physician: To the Examiner:On the ba	sis of examination	aye, death oc and/or investi	gation, in my	opinion, deat	h occurred	at the time,	date and pla	ace, and di	ue to the cause(s)
To th within	To tl	0	29b. Signature and title of ce	and mann	ner stated.			License num					ed (Month, Day, Year)
			1//	1	1 am			O.C.M.E.			Oct	ober 6,	2007
		-	30. Name and address of per	rson who completed	cause of death (Iter	m 23a)						·	
K			Melissa Brassell, N		Medical Exam	iner 111		eet, Baltin	nore, MI	D 21201			
	St	ate	31. Date filed (Month, Day, Ye	ear) 3	2. R oistrar's Signa	ture	melle				<u>-</u> _		
P	eaist		UUI	0 9 2007	THE PARTY OF THE P	1	-						

Registrar

07-07714 Eugene Farkas Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Lugerie i arkas	1- For State Registrar	Certificate of D		Reg. No.	6
Physician Medical Examine				of Death th Day Year ober 3, 2007 3. Time of Death 0021 hrs	
that y	4a. Facility Name (if not institution, give street and 2819 Orleans Street		City, Town, or Location of Death altimore	4c. County of Death	_
Funeral Director	5. Social Security Number 6. Sex 1 X M 2 F	I 54 17	to the December 1 March	te of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign Country) MI	
Aaryland 28a-f show any Littonee.	Usual Residence of Decedent  10a. State 10b. County  MD	10c. City, Town or Location Baltimore		10d. Inside City Limits 1 X Yes 2 No	
the Maryland Sa or 28a-f sho oiff of at once	10e. Street and Number 2819 Orleans Street	10	f. Zip Code 21224	10g. Citizen of What Country? USA	1
more, MD 21215-0036  Pages I and 2 should be filed within 72 hours after death with the Maryland Pert of Health and Mental Hygiene.  unt: If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once.  To Re Completed by Firnaral Director	Widowed 4 X Divorced if Yes, Give Y	Forces? If Yes, 1  aar 1 Ye  ade completed) 16a. Decedent's U	scedent of Hispanic Origin? (Specify Yespecify Cuban, Mexican, Puerto Rican, es 2 X No specify:  Isual Occupation (Give kind of work don for working life, DO NOT use retired)	white, etc. White Specify:	_
5-0036 led within 72 hour tygiene. other than "matter han "matter han "matter han "matter han "matter han he Medical Exa	12		employed  18. Mother's Name (First, N	vliddle. Maiden Surname)	_
21215 nould be file of Mental Hy is marked o tic event, th	John W. Farkas	19b. Mailing Ad	Mary A.	Suban ute Number, City or Town, State, Zip Code)	
more, MD 21215-00; Pages 1 and 2 should be filed within then of Health and Mental Hygiene, unt: If item 27 is marked other the other traumatic event, the Med To Be Comment the Med To Be Comment the Med Comm	Margaret Ferianc / S		5 Hawthorne Drive	20c. Location - City or Town, State	35
Baltimore, permit. Pages I ar Department of Hes Important: If ite injury or other tr	1 Burial 2 Cremation 3 X Removal 4 Donation 5 Other Specify: 21. Signature of Euneral Service Licensee	from State crematory or other Resurrection	place)		_
Physician Physician	23a. Part I. Enter the disease, or complications that	Challer Cha	rles L. Stevens Fi 1 FastFort Avenue	baltimore, MD 21230	ıt
/Medical -xaminer		c arrhythmia		Between Onset and Death	
ted Insit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a consequence of): Stenosis a consequence of):			_
execular and lan and lan and land land land land	d.  X UNPENDED AMENDED	o.27.perME.g872, 10/1			_
). Box 68760, the death certificate be by the attending physic ched for use as the bun Physician/Med		s, outcome of pregnancy		23d. Date of delivery  Month Day Year	
, P.O. Bries that the designed by the be detached by D.			rlying cause given in Part I. 23	e. Did tobacco use contribute to the cause of death?  Yes 2 No 3 Probably 4 Unknown	
cords law requi				a. Was an autopsy performed?  Yes 2 No 2 Yes 2 No 2 Yes 2 No 2 Yes 2 No 2 No 24b. Were autopsy findings available prior to completion of cause of death?	e
Vital Recystian: The his certificate director, page	25. Was case referred to medical examiner?	Inpatient 2 ER/Outpatient 3	26.Place of Death (Check only one DOA Other; Nursing Home		_
on of Vi nding Physi h. : After this e funeral dir	1 ✓ Yes 2 No  27. Manner of Death  1 X Natural 5 Pending	e of Injury th, Day, Year)		escribe how injury occurred	
Division o spital or Attending hours after death, uneral Director: After y filled in by the fune Certification:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined (Specify	ace of Injury - At home, farm, street, fa	ctory, office building, etc. 28f. Loc	cation (Street and Number or Rural Route Number, City Town, State)	
To the Hosp within 24 hos To the Fune completely fi		s of examination and/or investigation,	at the time, date and place, and due to t in my opinion, death occurred at the tim	he cause(s) and manner as stated. e, date and place, and due to the cause(s)	
F * F 8	29b. Signature and title of certifier  Add Hall	llan	29c. License number O.C.M.E.	29d. Date signed (Month, Day, Year) October 3, 2007	
0	30. Name and address of person who completed ca Carol Allan, MD Assistant Medica	, ,	et, Baltimore, MD 21201		
State Registra	000000000000000000000000000000000000000	histrar's Signature			

State Registrar Mecgan

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** October 04Day 2007 ear 11:45A M /Medical 4c. County of Death Baltimore 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Paradise Assisted Living Catonsville Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days 1□M 2X F Hours Yrs 215-09-5360 Director July 06, 1917 Maryland Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 28a-f show notified at 10b. County 1 Yes 2 No Directo Maryland Baltimore Catonsville the 10g. Citizen of What Country? 10e. Street and Number 10f. Zin Code o a Pages 1 and 2 should be filed within 72 hours after death with rent of Health and Mental Hygiene.

nt: If item 27 is marked other than "natural", or items 23a or nt: If item 27 is marked other than "natural", or items 23a or nt: If item 27 is marked other than "natural", or items 23a or nt. 6348 Frederick Road 21228 United States of America Completed by Funeral ırai", or items 2 Examiner mu 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 【XNO If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💹 No White 3 Widowed 4 Divorced Year or Dates: er than "nature, the Medical E 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Home Maker Own Home 7 is marked othe traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Edward Groh Elva Davis ္က 19a. Informant's Name/Relationship (Type. Frint) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jean S. Wheeler (Niece) 408 Prindle Court, Bel Air. Maryland 21015 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, Stat 1208 20a. Method of Disposition permit. Pages Department of Important: If it any injury or o 1 N Burial 2 □ Cremation 3 □ Removal from State \$t. Charles Church Cem 10/08/07 Pikesville, Maryland 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Loring Byers Funeral Directors, Inc. 21. Signature of Funeral S 8728 Liberty Road, Randallstown, Maryland 21133 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Imme late Cause (Final disease or condition resulting in death) **Physician** mont /Medical Due to (or as a nsequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of) physician the burial Physician/Medical attending p for use as IF FEMALE 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 □ Probably 4 □ Unknown 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an ate has by autopsy certificate 2 No 1∐ Yes 20€ No or Attending Physician: director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 200 No this funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: (Month, Day Year) Injury 10 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

Division or Vital Records, P.O. Box 68760,

ours after death. leral Director: A filled in by the fu To the Hospital within 24 hours a

To the Funeral I

completely filled

> State Registrar

DHMH 17 Rev 1/2001

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

405

30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

😰 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

			1 - State of Marylan	nd / Depa <i>Cei</i>	artment rtificate	of He	ealth ai	nd Me		giene Reg. No		32168
			Decedent's Name (First, Middle, Last)			0, 5			2. Date of De	ath		3. Time of Death
	Physicia		Newton J. Funkhouser					(	Month DCTD/SE/	Da と	y Year	2100 A-M-
	/Medic Examin		4a. Facility Name (If not institution, give street and number)		4b. City,	Town, or L	ocation of		00,000		County of Dea	
			Charlotte's Home		Вс	onsb	oro				Washing	gton
	Funeral Director		5. Social Security Number  428-30-2793  6. Sex 1 ★ M 2 □ F  81	last birthday) Yrs.	If Under Months	1 Year Days	Hours	Min	8. Date of Bir (Month, Da Dec 6,	th y, Year) 192	9. Bir C Ma	thplace (State or Foreign ountry) ryland
5			Usual Residence of Decedent									Tagara in Gradian
a Va	a how	-	10a. State 10b. County 10c. C	ity, Town or Lo								10d. Inside City Limits 1 ☐ Yes 2 ☐ No
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with	P O	Funeral Director	10e. Street and Number 212 Maple Avenue		10f. Zip	Code	2171	2		log. Ci	tizen of What C USA	ountry?
eath	ns 23	era	11. Marital Status 12. Was Decedent Ever in U	J.S. 13. V	Was Deced	ent of Hisc			cify Yes or No	.	14. Race - Am	encan Indian,
) il	and and	표	Armed Forces? 1 ☐ Never Married 2 ☐ Married 1 ☑ Yes 2 ☐ No					Puerto F	cify Yes or No Rican, etc.)		Black, Whi	_
	- 1	ρ	3 N Widowed 4 □ Divorced If thes, Give Year or Dates: 144	-46	1 ☐ Yes 2	XI No	Specify:				Specify: W	nite
72 h	nata Filosofi Filosof	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Deced	dent's Usua kind of wor DO NOT us	l Occupati k done du	ion ring most o	of workin	g	16b. K	and of Business	/Industry
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y pe	Hygie ther t nt. II		12 0	adm	inist			's Name	(First, Middle,			conautics
d be	Red o	To Be	Marvin Lionel Funkhouser						a Iren			
shoul	mari mari	F	19a. Informant's Name/Relationship (Type, Print)	19b. Mailir	ng Address	(Street an					or Town, State,	Zip Code)
2 500	atth a		Michael Funkhouser/son	5102	0bse	rvat	ion W	ay A	lexand	ria,	VA 223	312
2 - S	of He		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State	Place of Dispo cemetery, cren	sition (Nam	ne of ther place)		Dá	ate	20c. L	ocation - City or	Town, State
Pao	ment ant: I ury o		4 Donation 5 Other (Specify)	. 55								
Dermit in	Department of Health and Mental Hygiene. Important: if Items 23a or 28a-f ehow any Injury or other treumatic event, it a Medical Exactinational be notified at once.		21. Signature of Funeral Stryice Licensee Ronald S. Wade, Directo	r   S	Name and State Baltim	Anat	omy B	Soard 2120		. Ва	altimor	e Street
			25a. Part. Enter the disease, or complications that caused the dea shock or heart failure. List only one cause on each line.					ardiac or	respiratory a	rrest,		Approximate Interval Between
Pi	hysician		Immediate Cause (Final disease or condition	OCAR		7			1			Onset and Death
	Medical xaminer		resulting in death)  Due to (or as a conse		411		7 6.0	1	JUE			, , ,
_	Adminier		Sequentially list conditions, if any, leading to immediate  b. ATHEROSCU  Due to (or as a conse		CAR	Doug	ASCU	LAR	Sist.	4SE		YEMRS
ted	nsit	nlne	cause. Enter Underlying Cause (Disease or injury	quence or,								
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	physicien and s the burial-transit	dlcal	d									
tificat	g ph) as th											
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9 6	ed by the ettending p detached for use as	Physician/Me	in the past 12 months?  1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of 9 ☐ Unknown	death 5□	Other (spe	ecify)					Month	Day Year
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uires i	been signed t	d by	HYPERTEXON	<b>-</b>	,,	<b>y</b>				Yes 2		robably 4 Unknown
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he la	certificete hes rector, page 2	Completed	1841 RUAL MEISUAL DIE	702					autop	osy rmed2/	prior to death?	completion of cause of
an:	is certificete he director, page	0	25. Was case referred to medical				26. Place o	of Death	1 ☐ Yes	2 No	1 □ Ye	AGUED
ysici	direc	To B	examiner? 1   Yes 2   No   Hospital: 1   Inpatient 2	] ER/Outpatien	t 3 DO	Other			e 5 ☐ Resi		Other (Spe	PRINCE LIVING
) i	fter th		27. Manner of Death 1. Natural 5 □ Pending 28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28	Bc. Injury a Work?	at	2	8d. Describe i	how inju	ry occurred	FACILITY
tend;	er death. ector: After th by the funeral	catl	2 Accident investigation		М		s 2 N					
al or At	after d	Certification:	4 Homicide determined 28e. Place of Injury - At the building, etc. (Special Control of the Contr	nome, farm, str ify)	eet, factory,	, office		2	8f. Location (i City or Tou			ural Route Number,
To the Hospital or Attending Physician: The law requires that the death certificate be executed	within 24 hours after death.  To the Funeral Director: After this completely filled in by the funeral di	edical C	29a. Certifier (Check only one) Certifying Physician: To the best of my kn 2 Medicel Examiner: On the basis of examinand manner stated.	owledge, death ation and/or inv	occurred a vestigation,	at the time in my opir	, date and nion, death	place, a	nd due to the d at the time,	cause(s date an	) and manner a d place, and du	s stated. e to the cause(s)
To th	To th comp	Me	29b. Signature and title of certifier		29c.	License r	number			29d Da	ite signed (Mon	th, Day, Year)
•			Darch Vot Brade		7	138	872			10	0/1/07	
			30. Name and address of person who completed cause of death (Ite	m 23a) (Type,	Print) S	UITE	5 10	30		. 1	Hr	9652570JN.
			JAMELA FOX BRANGORD, M	\\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	10 M	601C	M	CA	TPUS	RA	MI	21742
	Sta Registr	-	31. Date filed (Month, Day, Year) 32 Registrár's Sign OCT 0 9 2007	A Long	well)							

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 4:20 P M Faulstich October 4, 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Greater Baltimore Medical Center Towson If Under 1 Year Baltimore 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 'ear If Under 24 Hrs. 5. Social Security Number **Funeral** Days Hours 1 □ M 2 🗓 F May 8, 1918 216-09-7440 89 Maryland Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County show r 28a-f show notified at 1 ☐ Yes 2 X No Director Lutherville Baltimore Maryland 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number an "natural", or items 23a or Medical Examiner must be 21093 U.S.A. 1414 Front Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 21 No White Specify: þ 3 ☑ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) the Own Home 12th. Grade Homemaker n and Mental Hygiv 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Joseph Francis Rosenberger Eva Weiss 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trau Rosenberger/Nephew 7143 Cunning Cr. Baltimore Charles 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1XXBurial 2 □Cremation 3 □Removal from State 4 □Donation 5 □ Other (Specify) 10/09/2007 Baltimore Most Holy Redeemer 22. Name and Address of Facility Miller-Dippel Funeral Home, Inc. 21. Signalus of Funeral Pervice Licence 21206 6415 Belair Road Baltimore ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, cause on each line. 23a. Part1. Enter the disease, or coms shock, or heart failed. List onl Approximate Interval Between Qnset and Peath Immediate Cause Final Physician NEUMONIA week disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner LUMONMEY URRONIC OBSTRNUTIVE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner requires that the death certificate be executed and use as the burial-tra Due to (or as a consequence of): Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 □Live birth 2 □ Fetal death 4 □Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 menths? 1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) signed by the a P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. or Vital Records, þ lanure 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 24a. Was an pate has page 2 s performed Yes 2 this certificate 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manne of Death 1 Natural To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) Division 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 33 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of de the trem 23a) (Type, Print)

STREET

BANIMORE MD 21204

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 19:15 M **Physician** arle Oct. 2007 E. Gaine /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number, Examiner Maryland Baltmore Mederal Ltr If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 🗹 F 219-28-6045 11· 23·1432 Director Virginia Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location r 28a-f show notified at 10a. State 1 ☐ Yes 2 ☐ No Director Jarrettsville MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code r than "natural", or items 23a or the Medical Examiner must be death with USA North Cliff Drive. <u> 21084</u> 2318 Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Pages 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2 ☐ Married 1□Yes 2₽No Baltimore, Maryland 21215-0036 Specify: Specify: Black 2 3 ₩idowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Baltimore City Elementary/Secondary (0-12) College (1-4or 5+) 10th Public School Cafeteria worker h and Mental Hygier is marked other th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be <u>Inasco</u> Haskins Sie muite 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) if item 27 is a318 North CLIFF Drive. Screethsville, mb 21084
tee of Disposition (Name of Date 20c. Location - City or Town, State Department of Health Important: If item 27 any injury or other troone. Valgene Gainey-Johnson 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 4 Donation 5 Dother (Specify) 10.12.2007 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Vaugnon C. Greene Funeral Services 4905 York Ad Bullimore, MD 21212 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** week /Medical Due to (or as a consequence of): icute Myelozencus Leukemia Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician a the burial Physician/Medical attending ph for use as the IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 No 4☐Pregnant at time of death 5 Other (specify) signed by the a 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an s certificate has b irector, page 2 sh autopsy performed? res 2 No 1□ Yes 25. Was case referred to medical examiner? director, 26. Place of Death Check onl one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ∐ Yes 🍇 No Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? (Month, Day Year) 5 Pending investigation Injury 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident Director: / 6 ☐ Could not be Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide within 24 hours after

To the Funeral Dire

completely filled in by 📂 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 1016

DHMH 17 Rev 1/2001

State

Registrar

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: Unwessing of

Maryland

Beltmore MD 21201

2. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Greene

OCT 0 9 2007

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Vear **Physician** Andrea Gentry October 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Bayview Medical Center

6. Sex 7. Age (In yrs. last birthday) Baltimore Johns Hopkins 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months | Days | Hours | Min. | (Month, Day, Year) 9. Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Months Days 1 □ M 2 🗷 F 214-78-9546 63-04-1964 Director Usual Residence of Decedent 10d. Inside City Limits . 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hyglene. tem 27 is marked other than "natural", or Items 23a or 28a-f show 10b. County 10c. City, Town or Location 10a. State ral", or Items 23a or 28a-f show Examiner must be notified at 1 Yes 2 □ No Baltmore MD Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number us 21213 3208 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: þ 3 ☐ Widowed 4 ☑ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) other traumatic event, the Medical (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Radislogist 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Informant's Name/Relationship (Type, Print) Pages 1 and 2 s ment of Health an 3208 Kentuck 1 move, MD 21213 item 27 Tavio 20b. Place of Disposition (Name of cemetery, crematory or other pl 20c. Location - City or Town, State 20a. Method of Disposition Department of Important: If it any injury or conce. 1 Burial 2 ☐ Cremation 3 Removal from State Moreland Mem 4 □ Donation 5 □ Other (Specify) 09 Chatman Haw in Belave 21. Signature of Funeral Service Licensee Hawls 21206 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) entricular 45 minutes Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner law requires that the death certificate be executed the burial-tran Due to (or as a consequence of) Box 68760. attending physician Physician/Medical as 1 IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day for in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) signed by the a P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, 2 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown ficate has been sig r, page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy pertormed? Yes 2XNo 1□ Yes certificate To the Hospital or Attending Physician: 124 hours after deatn.

Funeral Director: After this certification of the funeral director, aletely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2X No 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28a Date of Injury Certification: (Month, Day Year) Injury 1 XNatural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 ☐ Homicide 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 24 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Res -000 Akwaa Medical Doctor 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Akwaa Johns Hopkins Bayview Medical Center 4940 Eastan Avenue Baltimore MD 21224 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND TITEM 1 PERPHYS ne G872 Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Tina Louise Green-Holloway Year Month **Physician** 2007 02 October <del>Creen</del> /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Agnes Hospital Baltimore Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🗓 F 219-80-5085 Director 49 MD Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be noritinal once. 10c. City, Town or Location 10d. Inside City Limits 10a State 10h County 1 XYes 2 □ No Baltimore Director MD NA 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. 21216 2014 Braddish Ave by Funeral 14. Race - American Indian 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give X Year or Dates: 1 Never Married 2 Married Black Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Beauty Salon 12th grade Beautician 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Louise Belle Lee William Arthur Green Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20705 19a. Informant's Name/Relationship (Type. Print) 4727 River Creek Terrace, Beltsville, Md Randolph Green-Brother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 → Burial 2 □ Cremation 3 □ Removal from State King Memorial Park 10/12/2007 Randallstown, Md 4 Donation 5 Dother (Specify) 22. Name and Address of Facility March F/H West 4300 Wabash Ave, 21215 Baltimore, 23a. Pa /l. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shuck, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immeg ate Cause (Final Se/5. **Physician** a disea e or condition /Medical Due to (or as a consequence of): Examiner neumon. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine The law requires that the death certificate be executed HIV resulting in death) Last Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown 24b. Were autopsy findings available prior to completion of cause of death?

1 No 2 □ No 24a. Was an autopsy performed? 1X Yes 2 \( \sum \) No To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 🔀 Inpatient 2 ER/Outpatient 3 DOA ၉ 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Medical Certification: 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident To the Funeral Director: completely filled in by the 6 ☐ Could not be determined Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Y Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie

State

31. Date filed (Month, Day, Year)

X

Registrar
DHMH 17 Rev 1/2001

900 Caton AUC.

Baltimore Maryland 21229

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2007

DHMH 17 Rev 1/2001

Registrar

DANIEUL DOBERMAN MO

OCT 0 9 2007

31. Date filed (Month, Day,

6565

82. Registrar's Signature

CHARLES ST, SWITE 209, BALTIMONE, ND ZIZCH

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Vear Gresham **Physician** 6:00 AM Leslie 05 07 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Harford Bel Air 912 Rock Spring Road If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 8. Date of Birth (Month, Day, **Funeral** Year) 1 □ M 2 🔀 F 47 215-88-3610 Yrs. Oct. 18,1960 Maryland Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 □Yes X□No Harford Bel Air MD Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21014 USA 912 Rock Spring Road death ' Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status hours after 1 Never Married 2 Married Specify: white 1 ☐ Yes 2 X No Specify: ð 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 72 (Give kind of work done during most of working life. DO NOT use retired) filed within Elementary/Secondary (0-12) 1 2 Hair Cuttery and Mental Hygiene. College (1-4or 5+) Hair Stylist other traumatic event, permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked othe any injury or other traumatic event, once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Curtis Vanderbilt Martin Rhonda Burger 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Rudy Iozzi-spouse 912 Rock Spring Road-Bel Air, Maryland 21014 20b. Place of Disposition (Name of cemetery, crematory of other place)

Evans Funeral Chapel Oct.7,2007 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Forest Hill, Maryland 4 □ Donation 5 □ Other (Specify) And Cremations-Bel Air 22. Name and Address of Facility 21. Signature of Funeral Service License 3 NewportDrive 21014 Forest Hill, Maryland EVANS FUNERAL CHAPEL AND CREMATIONS SERVICE Part1/Enter the isease, or complications that caused the death, nock, or hear failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death ediate Cause 🖂 al **Physician** failure liver lease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury Due to (or as a consequence of): Examiner the death certificate be executed burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical the as IF FEMALE: 23c. If ves. outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 1 Live birth 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 📈 No 4☐Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown signed to 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>م</u> 1 ☐ Yes 2 ☐ No 3 A Probably 4 ☐ Unknown emphysema Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy page performed? 2 No Physician; 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No ပ funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours af To the Funeral D Hospital 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29b. Signature-and title of certifier

State Registrar

Maryland 21215-0036

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Records,

Vital

DHMH 17 Rev 1/2001

31. Date filed (Mont)

Bridge St. Elkton Md. 21921

30. Name and address of pers of who complete cause of death (Item 23a) (Type, Print)

g g M.D

egistrar's Signature

07-07787 Joseph Greaver

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2007 32175

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or Health of Heith 2		20a. Method of Disposition  1 XBurial 2 Crematic	on 3 R	lemoval from State	cre	matory or oth	ner place)			10/	10/20	07 D-	7.4.4		German Md
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036	ours after de re!', or items Examinar m	by Funeral	11. Marital Status 1 □ Never Married 2 ☒ Married 3 □ Widowed 4 □ Divorced	Ever in U.S.  No. 1951 1953  13. Was Decedent of Higher Specify Cubin 1 Properties 1 Properties 1 Properties 2 No. 1 Properties 2 No. 1 Properties 1 Properties 2 No.			spanic Origin? (S n, Mexican, Puerl Specify:	pecify Yes or No- o Rican, etc.)	14. Race - American Indian, Black, White, etc.  Specify: White			
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or vital Records, P.O. Box	ilicate be executed physicien and as the burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b. Due to (or as a consequence of).									
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	To the Hospital or Attending i within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Certification;	3   Suicide 6   Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)				eet, factory, office  28f. Location ( City or Tot			(Street and Number or Rural Route Number, wn, State)		
	To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by	Medical									I due to the cause(s)	
)	F3F8		D 18619 C						ad. Date signed (Month, Day, Year)			
	Sta	e_	VASANT DAT-	TA MO	340	MIL	L 1 T	HACER	5704~	mo:	21740	
	Registra	_	31. Date filed (Month, Day, Year)  OCT 0 9 2007	Bleson	B.	G234	2					

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760.

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

	J	1- For State Registrar	or Maryland /		tificate of		and wichte		eg. No. 20	07	3217
Physicia ledical Examir		1. Decedent's Name (First, Middle,Last)  Cora Bess Horner							2. Date of Death Month Day Year October 8, 2007  3. Time of Deat		
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or 909 Emory Church Road Upperco					m, or Location of [				
Funeral Director		5. Social Security Number 6. Se			st birthday)	If Under 1	Year If Under 2	Min	1	Countr	ace (State or Foreign y)
Director	- 1	160-20-3791 1 M XXF 83 Yrs. Months Days Hours Min. Jan.23,1924 Pennsylvania									
ow any		10a. State 10b. County MD Carro		•	Town or Location						d. Inside City Limits Yes 2 No
th the Maryland 23a or 28a-f show notified at once.	Director	10e. Street and Number			pperce	10f. Zip Co	ode	1	l0g. Citizen of What 0		
ith the last 13a or 100 tille		909 Emory Chu	rch Road		S 13 Was	Decedent	21155	? ( Specify Yes or No	U.S.	_	Indian, Black,
215-0036 be filed within 72 hours after death with the Maryland ntal Hygiene. rked other than "natural", or items 23a or 28a-f she ent, the Medical Examiner must be notified at once	Funeral	1 Never Married 2 Married	Armed Forces?	X No	If Ye	s, specify C	Cuban, Mexican, P	uerto Rican, etc.)	White, et	c.	
ours after atural" xamine	d by	15. Decedent's Education (Specify or	If Yes, Give Year or Dates: Ily highest grade com	pleted)	16a. Decedent	s Usual Oc	No specify:		Specify:	Whi ess/Indu	31
)36 thin 72 h ne. than "n	Completed	Elementary/Secondary (0-12) 1 2	College (1-4 or 5	+)	Ť	itor	g life. DO NOT us	e retired)	Social S Adminis		
215-0036 be filed within 7. ntal Hygiene. rked other than ent, the Medical		17. Father's Name (First, Middle, Last)  Alexander S					18.Mother's	Name (First, Middle,	Maiden Surname)		
2121 hould be fill and Mental Fill is marked ritic event,	_	19a. Informant's Name/Relationship (T	ype, Print )	-			Street and Number	er or Rural Route Nu	felfinge mber, City or Town, S	tate, Zıp	
e, MD 2121 I and 2 should be f Health and Mental iten 27 is marked		Henry J. Horner, 20a. Method of Disposition	III / S	on 20b. F	909 Place of Disposit			ch Road,	Upperco		
Baltimore, MD 21 permit. Pages I and 2 should Department of Health and Me Important: If item 77 is ma njury or other traumatite ev		1 Burial 2XX Cremation 3 Donation 5 Other Specify:		me t	rematory or other	er place) mato	ry Inc.		Baltim	•	-
Baltimore permit. Pages I Department of I Important: If i	1	21. Signature Funeral ervice License 22. Name and Address of Facility Eckhardt Funeral chapel P.A.  11605 Reisterstown Rd. Owings Mills, MD2111									
Physician /Medical		23a. Part I. Enter the disease, or comp failure. List only one cause on ea	lications that caused to	the death.	Do not enter the	e mode of d	lying, such as card	diac or respiratory ar	rest, shock, or heart	A	S MDZ I I I Approximate Interval Between Onset and
xaminer	İ	Immediate Cause (Final disease or condition resulting in death)  a Malnutrition and dehydration  Due to (or as a consequence of):									
	<u>-</u>	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):  Due to (or as a consequence of):									
Ţ	Examiner	Cuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conse	quence of	):					+	
executed in and il - transit		X UNPENDED	AMENDED		_					+	
760, icate be physicial the buris	= 1	IF FEMALE:	AMENDED 1, 2 #23a, PII, 2	7 <b>, perl</b> le of pregr	1E,g874, 1 nancy	2/5/07	TT		23d. Date of deli	very	
Sox 687 leath certific e attending for use as t	Physician	23b. Was decedent pregnant in the past 12 months?  1 Yes 2 ✓ No 9 Unknown	1 Live birth 4 Pregnant at t	ime of dea	-41-	al death er <i>(Specify</i>	3Ectopic p	regnancy	Month	Day	Year
C. Box of the death of by the attendached for us		1 Yes 2 No 9 Unknown  Part II. Other significant conditions	9 Unknown	but not re	esulting in the ur	iderlying ca	use given in Part	I. 23e. Did t	obacco use contribute	e to the	cause of death?
S, P.O uires that t n signed by	ed by										
of Vital Records, ag Physician: The law require ther this certificate has been si neral director, page 2 should be	Completed	dementia		···		-			psy prior deat	to comp	sy findings available pletion of cause of
tal Rection: The	Be Co	25. Was case referred to medical				26.	Place of Death (C	1 Yes	2 No 1	Yes	2 No
of Vit. Physici er this c	<u>۵</u>	examiner? 1 Ves 2 No 27. Manner of Death	lospital: 1 Inpatier		ER/Outpatient 28b. Time of In		Other 1 1	Nursing Home 5	Residence 6 🗸 0	ther: Sc	ene
ion of ttending P leath. tor: After the funera	ation:	1 X Natural 5 Pending 2 Accident Investigation	28a. Date of Injur (Month, Day,Ye	ear)	200. 71110 07 111		Yes 2 N		now injury occurred		
Division tal or Attendin us after death. al Director: A	Certification:	3 Suicide 6 Could not l	be 28e. Place of Inj	ury - <b>A</b> t ho	ome, farm, stree	, factory, of	fice building, etc.	28f. Location or Town,	(Street and Number o State)	r Rural F	Route Number, City
	Medical C	29a. Certifier (Check only)  29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
F 3 F 8	ğ	29b. Signature and title of certifier	1 11	//			o.C.M.E.	<del>-                                    </del>	29d. Date signed		Day, Year)
	}	30. Name and address of person who completed cause of death (Item 23a)									
Jack Titus MD. Deputy Chief Medical Examiner 111 Penn Street, Baltimo						Baltimore, M	D 21201				
Sta Registi		OCT 0 9 2087	The Sure	1	10000						

State of Maryland / Department of Health and Mental Hygienes For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Detobe Edward J. Happel 200 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore-Washington Medical Center Glen Burnie Anne Arundel If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) Jan. 24, 1 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex **Funeral** 1X M 2 ☐ F 219-10-8095 81 Director 1926 Maryland Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits "naturel", or iteme 23a or 28e-f ehow permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryla Depertment of Health end Mentel Hyglene. Important: if item 27 is marked other than \*nature!', or iteme 23a or 28e-f ehoven important: if item 27 is marked other than \*nature!', or iteme 23a or 28e-f ehoven hy injury or other treumatic event, ite Mudical Exartement must be rutified at once. 1 Yes 2 No Maryland Anne Arundel Glen Burnie Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 117 Glenlea Drive 21061 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 XYes 2 □ No If Yes, Give Year or Dates: WW II 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ 3 Widowed 4 □ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Crane Operator Government 18. Mother's Name (First, Middle, Maiden Sumame) Be 17. Father's Name (First, Middle, Last) William Happel Madeline Dew 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Karen Vacek / Daughter 8025 Foxtail Lane, Glen Burnie, Maryland 21061 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State October 9 2 Cremation 3 Removal from State 1 K Elurial Glen Haven Mem. Park 2007 5 Other (Specify) Glen Burnie, Maryland 4 Donation 22 Name and Address of Facility
Kirkley-Ruddick
421 Crain Hwy., S.E., Glen Burnie, 21. Signal e of Fun rai Servi Licens O enter the disease. Maryland 21061 or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Betw shock, or heart failure. List only one cause on Immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** /Medical Examiner Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that inflated events resulting in death) Last Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires thet the death certificate be executed burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 Probably 4 Unknown Completed 1 Tes 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performe res 20 1 ☐ Yes 2 ☐ No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: npatient 2No Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Yes 2 ER/Outpatient 3 DOA this 27. Manner of Peath
1 Natural
2 Accident te of Injury Month, Day Year) Certification; 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t Injury 5 Pending within 24 hours after death.

To the Funeral Director: A completely filled in by the fu М 1 ☐Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1/ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2/ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) the e 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number M son who completed cause of death (Item 23a) (Type, Print) 30 Name and Registrar's Sign vure State Registrar

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 5, Hylock October 2007 May 9:43 A 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 7935 St. Gregory Drive Dundalk BAltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days Hours 1 M 2 F 218-42-5814 62 January 15, 1945 Maryland Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 X Yes 2 □ No Maryland N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 524 S. Bouldin Street 21224 USA Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2X☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 XNo Specify Specify: White 3X Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Housewife 9 vears 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Milton E. House Clara Marie Evans 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2006 Denbury Drive, Baltimore, Maryland 21222 Frances R. Stankiewicz sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State October 1 XBurial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify) 3 ☐Removal from State Garrison Forest VA Owings Mills, MD. 2007 21. Signature of Funeral Service Licensee Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, MD. 21222 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. 23a. Part1. Enter the disease of shock, or heart failure. List Approximate Interval Between Onset and Death Immediate Cause (Final YES disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Error Underlying Cause (Disease or injury Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 24b. Were autopsy findings available prior to completion of cause of death? 1 □ You 2 □ No 24a. Was an autonsy perfor 1∐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other (Specify) Son's Hospital Other: 4 Nursing Home 5 Residence 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No □ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide

Box 68760 P.O. Records, Division br Vital

To the Hospital

within 24 hours a To the Funeral I

Physician

/Medical

Examiner

**Funeral** 

Director

show

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29a. Certifier

(Check only one)

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Hygiene.

marked other

1 and 2 should be fill Health and Mental H em 27 is marked oth

permit. Pages 1 and 2 Department of Health a Important: If item 27 is

death v

72 hours after

Baltimore, Maryland 21215-0036

Director

Funeral

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Completed

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State Registrar

nanner stated.

29c. License number

be best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and

1 Certifying Physician: To 2 Medical Examiner: On the

1425

07-07767 Karen Harrison

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2007 32181

			For State		,	Certi	ficate of	Death				R	eg. No.				_
Physic	ciar		egistrar . Decedent's Name (First, Midd	le,Last)							1	Date of Dea Month	Dav	Year	3.	Time of Death 0945 hrs	
Exar			KAREN ANN HAI	RRISO	N							October 5	, 2007				4
		4	a. Facility Name (if not instituti			er)		4b. City, Tow		cation of	Death		4c. C	ounty of	Death		4
			Maryland General Ho	spital				Baltimo					В	ALTŢ	MORE	CITY	4
Funera	al	5	Social Security Number	6. Sex	7.7	Age (In yrs. las	t birthday)	If Under 1	Year			8. Date of B	rth(MM/DE	)/YYYY)	<ol> <li>Birthp</li> <li>Foreign</li> </ol>	lace (State or	
Directo			46.54.4056	1 M	2 V F	57	Yrs	Months	Days	Hours	Min.	JAN.	29 1	1	Count	MARYLAND	
			16-54-1056 Usual Residence of Decedent	101	- 4							OZIIV.		<u> </u>			_
any	1	-	0a. State 10b. County			10c. City, T	own or Loca	tion							11	0d. Inside City Limits	;
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Mary 28a	be notified at once.	Director	0e. Street and Number					101.2.0				1					
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with ms 2	a P	<b>あ</b> Ⅰ	11. Marital Status		<ol><li>Was Deceded</li><li>Armed Force</li></ol>	ent Ever in U.S	i. 13. W	as Decedent Yes, specify (	of Hispa Cuban, I	anıc Origi Mexican,	n / (Spe Puerto F	Rican, etc.)	10-	White,		ir malan, Bask,	- 1
death	must	5		Married 1	Yes	2 X No		1						naaifi.			Į.
after	ner	ğ L		OF	Yes, Give Year Dates:		1	Yes 2 X				-1. 10		pecify: nd of Bus	WHI'		$\dashv$
ours	xam		15. Decedent's Education (Sp.	ecify only h			16a. Decede during r	nt's Usual Od nost of working	ccupationg life. [	on (Give K DO NOT (	ina of wi use retire	ed)	100. Kil	10 01 203	111633/1116	Justi y	ì
72 h	E	Completed	Elementary/Secondary (0-12	(1)	College (1-4	or 5+)											-
036 ithin 73	ledio	튑	12				CLERI	CAL				(E)		FICE			$\dashv$
5-0 ed w tygic othe	The S	3	17. Father's Name (First, Midd	e, Last)					- 1			(First, Middle					-
21215-0036 wild be filed within 7 Mental Hygiene. marked other than	ent,		BERNARD JOHN							DIAN	E MA	ARGARE	r WOR	KMEI	STER	Zin Codo)	$\dashv$
ore, MD 21215-0036 ss I and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f she	ic ev	၉	19a. Informant's Name/Relation	nship (Type			19b. Maili	ng Address	(Street	and Num					i, State,	Zip Code)	
MD d 2 shc lith and m 27 is	nma	ļ	LINDA KLIPA-G	RANDI	SON / S	SISTER		STEWAR'			GI	LEN BU			210	061 own, State	$\dashv$
e, – I and Heal	r tr	Γ	20a. Method of Disposition		- 16		lace of Disportant or of the control	osition (Name other place)	of cem	etery,	ОСТ	Date 8,	200. Li	oçation -	City of 1	OWII, State	- 1
Lor nt of t: If	othe	1	1 Burial 2 X Cremati		Removal from	State	-	EMATOR	37			2007 _	CAT	rontet	/TT.T.?	E. MARYLAN	וסמ
Baltimore, permit. Pages I a Department of He Important: If ite	injury or other traumatic event, the Medical Examiner must		4 Donation 5 Other 21. Signature of Funeral Servi		e	MET	22	Name and A	ddress	of Facility	,					7 1 11 11 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	$\neg$
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Medic			failure. List only one cau	se on each	ı line.	arrythmia										Death	``\
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68 ertifi	se as	ian	past 12 months?		1 Live bir 4 Pregna	tn nt at time of de					o progra	anoy				•	
Box 68 e death certif	for us	sician	1 Yes 2 No 9 🗸	Unknown	g Unknov		5	Other (Spec	<i>uy)</i> _								- 1
He de	signed by the attending be detached for use as	Phys	Part II. Other significant cor	ditions o			esulting in th	e underlying	cause g	iven in P	art I.	23e. D	id tobacco	use cont	ribute to	the cause of death?	
that that	deta	þ										1	Yes 2	<b>/</b> No 3	Prot	oably 4 Unknow	vn
S, –	ld be	eq										24a. V	/as an	24b.	Were au	topsy findings availa	able
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Division of Vital Records, P.O. ral or Attending Physician: The law requires that the star after death.	rtific tor, p	O e	25. Was case referred to med	dical				- 2	26.Place		(Check	only one)					$\dashv$
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of \	iter ti ieral	$\vdash$	27. Manner of Death		28a. Date o	of Injury Dey,Year)	28b. Time	of Injury 2	28c. Inju	ıry at Wo	k?	28d. Desci	ibe how inj	ury occu	rred		
P di di	r: A ne fur	io		Pending	,	boy, roar,		1	1	Yes 2	No						
Sic Atte	ecto by th	ica		nvestigatio	28e. Place	of Injury - At h	nome, farm, s	treet, factory	, office !	building,	etc.		on (Street a	and Num	ber or Ri	ural Route Number, (	City
al or	ed in	Certification:		Could not b letermined								OI TOV	vii, State)				
ospit hour	y fill		29a Certifier	a Physicis	n: To the hest	of my knowled	dge, death o	ccurred at the	time, d	ate and p	lace, an	d due to the	cause(s) a	nd mann	er as sta	ted.	
Division of Vital Records, P.O. Box 687 To the Hospital or Attending Physician: The law requires that the death certification of the control	To the Funeral Director: After this certificate has been seem sompletely filled in by the funeral director, page 2 should	edical	(Check only 1 Certifyin one) 2 Medical	Examiner:	On the basis of	f examination	and/or invest	igation, in my	opinio	n, death d	occurred	at the time,	date and pl	ace, and	due to th	ne cause(s)	
To T	To To	Med	29b. Signature and title of ce		and manner st	ated.				se numbe						onth, Day, Year)	
		_		- 1	W	0.		}	O.C	.M.E.			Oc	tober 6	3, 2007	•	
			Malpinte	- Ur	ne or	ull											
7	_		30. Name and address of pe		completed caus	e of death (Iter	m 23a) nor 11:	1 Penn Str	reet F	3altimo	re. MF	21201					
			Margarita Korell M			fical Exami			JUL, L					000	78.0		
		tate			Fa. Re	gistrar's Signa	Jule 1	de						OCI	ME		
R	egis	गार	nrt 0.9	2007	The same												

			State of Maryland / [	Department of Health a	and Mental Hy	giene
			Registrar  1. Decedent's Name (First, Middle, Last)	Certificate of Death	2. Date of De	Reg. No. 2007 32182
	Physici /Medic		EUGENE	HEILMAN	Month OCTOBER	Day Year
,	Examir		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of		4c. County of Death
		46	FOREST HILL HEALTH & REHAB CENTER			HARFORD
	Funeral Director		5. Social Security Number 6. Sex 152M 2 F 7. Age (In yrs. last bir	thday) If Under 1 Year If Under 2  Yrs. Months Days Hours	Min. (Month, Da	y, Year) Country)
			Usual Residence of Decedent		March 4	1925 Maryland
	arylan show d at	_	10a. State 10b. County 10c. City, Tow			10d. Inside City Limits
	the Mi	Director	Maryland Harford County Fores	10f. Zip Code		1 ☐Yes 2 No  10g. Citizen of What Country?
	3a or	Dig	1225 Walters Mill Road	21050		United States
	ems 2	Funeral	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Onc If Yes, specify Cuban, Mexican	gin? (Specify Yes or No	
30	be filed within 72 hours after death with the Maryland tal Hygiene. d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by Fu	1 Never Married 2 Married 1 Married 2 No If Yes, Give	1 ☐ Yes 2 🔼 No Specify:	, rue to ritoan, etc.;	Specify: White
2-0036	tural	ed b		Decedent's Usual Occupation		16b. Kind of Business/Industry
ر اح 1	thin 72 e. an "na Media	Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)	(Give kind of work done during most life. DO NOT use retired)	of working	
7	filed wit Hygien other tha	Con	10 N/A (	arpenter		Construction Company
and	l be fil ntal H ed ott	Be	17. Father's Name (First, Middle, Last)		r's Name (First, Middle,	, Maiden Surname)
5	2 should be and Mental is marked o	은	Albert J. Heilman  19a. Informant's Name/Relationship (Type. Print)  19b	. Mailing Address (Street and Numbe		er, City or Town, State, Zio Code)
ĭ Zaa	and 2: salth a n 27 is ier trat					est Hill MD 21051
e,	e te iii		20a. Method of Disposition 20b. Place of cemete	f Disposition (Name of ry, crematory or other place)	Date	20c. Location - City or Town, State
saitimore	trent of trant: If its ijury or o		4 Donation 5 Other (Specify) Evans 7	meml Chapel 10	ct. 8, 2007	Forest Hill, MD Services - Bel Air
g	permit. Pages Department of Important: If i any Injury or once.		21. Signature of Funeral Service Licensee	22. Name and Address of Facility	14 Chematian	Services - ibel Air
			23a. Part1. Enter the disease, or complications that caused the death. Do			rrest, Approximate
	Physician		shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition			Interval Between Onset and Death
	/Medical		resulting in death)  a.  Due to (or as a consequence	of):		
	Examiner	Į.	Sequentially list conditions, if any, leading to immediate b. Due to (or as a con) guence	of):		
	uted d ansit	Examine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	51).		
Ď	e exection and and and and and and and and and an		resulting in death) Last  Due to (or as a consequence	of):		
0/00 0/00	requires that the death certificate be executed een signed by the attending physician and nould be detached for use as the burial-transit	dical	d			
Ď X	death certifica attending pt for use as t	/Med	IF FEMALE: 23c. If yes, outcome pf pregnancy			Old Date of deliver
DOX	death atten d for u	hysician/Me	1 Live birth 2 Fetal death in the past 12 months?  1 Ves 2 No 4 Pregnant at time of death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delivery  Month Day Year
5	at the by the tacher	hys	9 Unknown 9 Unknown			
S,	w requires that the de been signed by the should be detached	by P	Part II. Other significant conditions contributing to death but not resulting in	the underlying cause given in Part I.		obacco use contribute to the cause of death?
cords		eted				Yes 2 No 3 Probably 4 Unknown
ž L	slcian: The law certificate has b irector, page 2 sh	Completed			—— 24a. Was autop perfo	
VII.		Be Co	25. Was case referred to medical	26 Place	of Death (Check only of	2 No 1 □Yes A□No
>	nyslci nis cer direct	To B	examiner? 1   Yes 2   No   Hospital: 1   Inpatient 2   ER/Ou			dence 6 ☐Other (Specify)
	Ing Pl		Natural 5 Pending (Month, Day Year) I	Time of 28c. Injury at mjury Work?	28d. Describe	how injury occurred
200	ttend death ctor: /	icati	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of injury - At home, fa	M 1 ☐ Yes 2 ☐ N		Street and Number or Rural Route Number,
5	after after I Direct	Certification:	4 Homicide determined building, etc. (Specify)	m, allost, radioly, onloc	City or To	wn, State)
1	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director,		29a. Certifier (Check only (Ch	e, death occurred at the time, date and	d place, and due to the	cause(s) and manner as stated.
)	the H hin 24 the F mplete	Medical	one) and manner stated.	29c. License number		
	J. W. L	=	29b. Signature and title of certifier			29d. Date signed (Month, Day, Year)
•	IXO		30. Name and address of person who completed cause of death (Item 23a) (	(Type, Print)	75	Cotalus 8, 2007
	J'		DAVID DUNN - 615 W. MACPHAIL ROA	AD - BEL AIR, MI	21014	
	Sta		31. Date filed (Month, Day, Year) OCT 0 9 2007	Anast. 2		
	Registr	ar	OUT OF EAST AS			

DHMH 17 Rev 1/2001

DHMH 17 Rev 1/2001

State Registrar

Mukemil\_

F. Abdella, MD 3001 Hospital Dr., Cheverly, MD 20785 32. Registrar(s Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year) OCT 0 9

Bloom & April

2005998

October 5,2007

Registrar

DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

OCT 0 9

strar's Signature

07-07840 Hance Hopkins Hall

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2007 32185

i iai io	e i lopkilis i	1	For State Certific	cate of Death	Reg. No.
	Physicia		egistrar I. Decedent's Name (First, Middle,Last)		2. Date of Death 3. Time of Death Month Day Year 2047 hrs
M	al Examii	ner	Hance Hopkins Hall		October 7, 2007
			a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death  Dundalk	Baltimore County
			126 Patapsco Avenue  5 Social Security Number    6 Sex    7 Age (In yrs. last bil		
	Funeral Director		70	Months Days Hours Min	Eoroign
	Director	L	218-30-6775 1 M 2 F 72	, Yrs.	7-217133 111
	any	-	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town	n or Location	10d. Inside City Limits
	2		MD Balhmore Dur	vdalk	1 Yes 2 No
_	ne Maryland or 28a-f show fred at once.	윉	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
7	the Man or 2	Director	126 Patapsco Avenue	21222	U.S. A.
0	1715-0036 Id be filed within 72 hours after death with the Maryland hardl Hygiene and arked other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at once.	uneral	11. Marital Status 12. Was Decedent Ever in U.S.	13. Was Decedent of Hispanic Origin? ( S If Yes, specify Cuban, Mexican, Puerto	pecify Yes or No- p Rican, etc.) 14. Race - American Indian, Black, White, etc.
	or iter	Ĕ	1 Yes 2 No		specify: White
	after	by F	3 Widowed 4 Divorced If Yes, Give Year or Dates:	1 Yes 2 No specify:  a. Decedent's Usual Occupation (Give kind of	
	hours natu	ed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4 or 5+)	during most of working life. DO NOT use re	tired)
	36 thin 72 than than edical	ble	i /	Steel Worker	Signode
	215-0036 be filed within 7 mtal Hygiene. rked other than ent, the Medica	Completed	17. Father's Name (First, Middle, Last)	18.Mother's Nam	ne (First, Middle, Maiden Surname)
	215 215 oe file rked o	Be (	Ellis Hall	Eva	Wilforg
	D 21215-003 should be filed within and Mental Hygiene. 7 is marked other th natic event, the Med	2	19a. Informant's Name/Relationship (Type, Print )		Rural Route Number, City or Town, State, Zip Code)
	imore, MD 2 Pages I and 2 shou nent of Health and N iant: If item 27 is n or other traumatic		JOANNA S. Hall- Wife	126 Patabsco Ave., e of Disposition (Namé of cemetery,	Date 20c. Location - City or Town, State
	of Heal	-	1 Burial 2 Cremation 3 Removal from State crem		1
	Page Page ment tant: or ot			view Crematory 10-	-4-0+ Daltimore, IND
	Baltimore permit. Pages 1 st Department of Ho Important: If it injury or other t		21. Signature of Funeral Service Licensee	22. Name and Address of Facility Br	adky-Ashton aneral Home, Spring Rd., 21222
		-	23a. Part I. Enter the disease, or complications that caused the death. Do	not enter the mode of dying, such as cardiac	or re-piratory arrest, shock, or heart Approximate Interval
4	hysician Medical		failure. List only one cause on each line.		Between Onset and Death
	≟xaminer		Immediate Cause (Final disease or condition resulting in death)  a. ALTIETOSCIETOLIC Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):	il ullovascular uliscasc	
			Sequentially list conditions, b		
		iner	if any, leading to immediate Due to (or as a consequence of):		
	H-	Examine	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):		
	ecuted and transit		d		
	y se exe cian a rrial -	Medical	XUNPENDED AMENDED 4.27, perME, g8	72,10/22/07 TT	
	760, icate be exe physician at the burial -		IF FEMALE: 23c. If yes, outcome of pregnan	ncy	23d. Date of delivery  nancy Month Day Year
	certif certif anding ise as	sician	23b. Was decedent pregnant in the past 12 months?  1 Live birth Pregnant at time of death	2	,
	Box 687  e death certific  the attending p  ed for use as the	ly Si	1 Yes 2 No 9 Unknown g Unknown		
	O. I at the d by tl	Phy	Part II. Other significant conditions contributing to death but not resu	Iting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?  1 Yes 2 ✔ No 3 Probably 4 Unknown
	ires the signe	d by			- 1 - 200 - 2
	rds v requ s been	Completed			autopsy prior to completion of cause of
	eco he law ate has	E			performed?  1 ✓ Yes 2 No 1 ✓ Yes 2 No
	Nr. T	B B B	25. Was case referred to medical	26.Place of Death (Che	photonics.
	Vita hysicia this ce	B	1 Yes 2 No		rsing Home 5 Residence 6 V Other: Scene
	Of ing Pl	=	(Month, Day,Year)	8b. Time of Injury 28c. Injury at Work?	28d. Describe how injury occurred
	tend tend death.	atic	1 X Natural 5 Pending 2 Accident Investigation		28f. Location (Street and Number or Rural Route Number, City
	Division of Vital Records, P.O. tal or Attending Physician: The law requires that the safter death.  The above the sertificate has been signed by led in by the funeral director, page 2 should be deach.	Certification: T	3 Suicide 6 Could not be determined (Specify)	e, farm, street, factory, office building, etc.	or Town, State)
	Division Hospital or Attend 24 hours after death. Funeral Director:	ق	4 Homicide  29a. Certifier  Certifying Physician: To the best of my knowledge	doath accurred at the time, date and place,	and due to the cause(s) and manner as stated.
	Division of Vital Records, P.O. Box 68760,  To the Inceptial or Attending Physician: The law requires that the death certificate be executed within 24 hours after death  To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in white funeral director, page 2 should be detached for use as the burial - transi	Medical	one) 2 Medical Examiner: On the basis of examination and	, death occurred at the time, date and place, to l/or investigation, in my opinion, death occurre	ed at the time, date and place, and due to the cause(s)
	To t With To t	Ved	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
			19/21	O.C.M.E.	October 8, 2007
	1	1	30. Name and address of person who completed cause of death (Item 2	3a)	
	.//	1	David Fowler M.D. Chief Medical Examiner 11	1 Penn Street, Baltimore, MD 212	01
		Stat	31. Date filed (Month, Day, Year) 32. Figistrar's Signature	Bull 1	
	Regi	stra	DET 0 5 2007   Blocker &	- Agree	

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Second Security Numbers   Second Numbers   Security Numbers   Securi									- 0	Location o	f Death		Ł			
The state of the s	1											8 Date of R				
Continued   Cont	н			·							Min.	(Month, D	ay, Yea	r)	Country	()
The content of the co		pu ,		Usual Residence of Decedent		100 City T	'oum or L	netion							100	I Inside City Limite
The content of the co		faryla shov	ō		undol										100	
The content of the co		the A	rect		didei	GIEII	Duri		Code				10g. C	Citizen of What	Country	y?
The content of the co		th with 23a or ist be	al D	7678 Mueller Dr.				210	60				US	SA		
The content of the co		r dea	uner	11. Marital Status	Armed Forces	?	13.	Was Deced If Yes, spec	dent of Hi	spanic Orig n, Mexican	gin? (Spe , Puerto F	cify Yes or N Rican, etc.)	0-			
The content of the co	36	rs afte			I 1 ☐ Yes 2 ☑ If Yes, Give	No		1 ☐ Yes 2	<b>2CX</b> No	Specify:				Specify:	whi	te
The content of the co	9	2 hou latura ical E	ted	15. Decedent's	Education	- 11	6a. Dece	dent's Usua	al Occupa	ition			16b.	Kind of Busine	ss/Indu	stry
All	215	ithin 7 ne. nan "n	nple		<del></del>				rk done d se retired,	uring mosi )	ot workir	ng				
All	121	Hed wi	Co	17 Father's Name (First Middle La	et)	H	lomem	aker	1	18 Mothe	r's Name	/First Middl				
All	anc	d be f ental h ced of	o Be		Si)								s, maice	ni Guiname)		
All	ary	shoul and Me s mark	Ĕ		(Type. Print)		19b. Maili	ng Address					ber, City	or Town, Stat	e, Zip C	code)
All	Σ	and 2 ealth a n 27 ls		Mr. Virgil E. Ho	lland/Husba								· ·			
All	ore	ges 1 t of He if iten or oth		1 ☐ Burial 2 ☐ Cremation 3	☐Removal from State	20b. Plac cem	e of Disp etery, cre	osition (Nan matory or o	ne of ther place	e) 0			20c.	Location - City	or Tow	n, State
23a. Part I Erse the selection or correlations as a cause of respiratory arrest.    Physician   Medical Exampling in death	亞	it. Paritmen rtant: njury				Chesa						07	Ste	evensvi	11e	, MD .
23a. Part I Erse the selection or correlations as a cause of respiratory arrest.    Physician   Medical Exampling in death	Ba	Depa Impo any i		21. Signature of the error Service Life	ensee	M0141	1   S	ingle	ton	Funer	al a					es
The default of the part of the				23a. Part1. Enter the disease, or co	omplications that cause	d the death. I								1D 2100	1	Approximate
Medical Examiner    Medical Examiner   Medical Exam		Physician		Immediate Cause (Final disease or condition			ardi	alin	ford	in						
Sequentially list conditions are acrossopressed by the confidence of the cause of control of the cause	7			resulting in death)	- C.		-								1	1.
The state of the s		- Adminior	<u>-</u>	Sequentially list conditions,	b. <u>Sep114</u>	Sho	(K	7.			ec.		-		(	944
The contribution of the		uted	min	cause. Enter Underlying Cause (Disease or injury	acte			prel	واماء	Isa	hami	boo	nd)			1 day
See a see a	0	e exec ian an ırial-tr		resulting in death) Last	Due to (or as	a consequen	ice of):	1					-			
State   Stat	876	cate by	dica		d										+	<del>_</del>
State   Stat	9 x	certific iding p	/Me		23c. If yes, outcome	pf pregnance	v							22d Date of	dolivon	
State   Stat		death e atter d for u	iciar	in the past 12 months?	1 ☐Live birth 4 ☐ Pregnant a	2 Fetal de	ath 3									
State   Stat	0.	at the by the tache	hys	9 ☐ Unknown												
24a. Was an autopsy findings available growing autopsy performed?   1   Yes 2   No   No   No   No   No   No   No		res tha		11 1 1		1			ause give	en in Part I.						
State   Stat	Š	. 2 -	eted	104/2013/200	19pe # 41	69263	10190	NI VE	mi	Colone						
29a. Certifier (Check only one)  29a. Certifier (Check only one)  29a. Certifier (Check only one)  29b. Signature and due to the cause(s) and manner as stated.  29c. License number (29d. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  31. Date filed (Month, Day, Year)  32. Pegistrar's Signature  32. Date filed (Month, Day, Year)  32. Pegistrar's Signature	Rec	he lav e has ige 2 s	ldm	proumonic								aut	opsy	prior deat	to comp 1?	oletion of cause of
29a. Certifier (Check only one)  29a. Certifier (Check only one)  29a. Certifier (Check only one)  29b. Signature and due to the cause(s) and manner as stated.  29c. License number (29d. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  31. Date filed (Month, Day, Year)  32. Pegistrar's Signature  32. Date filed (Month, Day, Year)  32. Pegistrar's Signature	ta	an: T tificate tor, pa			-					26. Place	of Death			Vo 1□'	es 2	□ No
29a. Certifier (Check only one)  29a. Certifier (Check only one)  29a. Certifier (Check only one)  29b. Signature and did title of certifier  29c. License number  29d. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  31. Date filed (Month, Day, Year)  32. Registrar's Signature  32. Registrar's Signature	Γ	nysici nis cer i direct			Hospital: Inpati	ent 2 ER	/Outpatie	nt 3 DC	Othe					6 □Other (S	Specify)	
29a. Certifier (Check only one)  29a. Certifier (Check only one)  29a. Certifier (Check only one)  29b. Signature and did title of certifier  29c. License number  29d. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  31. Date filed (Month, Day, Year)  32. Registrar's Signature  32. Registrar's Signature	n o	fter		1 Natural 5 ☐ Pending	(Month, Da							8d. Describe	how in	jury occurred		
29a. Certifier (Check only one)  29a. Certifier (Check only one)  29a. Certifier (Check only one)  29b. Signature and did title of certifier  29c. License number  29d. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  31. Date filed (Month, Day, Year)  32. Registrar's Signature  32. Registrar's Signature	isio	ttend death. stor: /	icati	2 Accident investigat 3 Suicide 6 Could no	be 200 Place of in	iun: • At home	farm st			Yes 2□1		9f Location	(Stmot)	and Number o	- Duml	Pouto Number
29a. Certifier (Check only and manner as stated. 29b. Signature and title of certifier and manner stated. 29c. License number 29d. Date signed (Month, Day, Year)  29a. Certifier (Check only and manner as stated. 29b. Signature and title of certifier and manner stated. 29c. License number 29d. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  57Loot Jacobs mp 30s Jospt Jh. Glen Burne, MD 3106	Div	after after I Direct	ertif	4 ☐ Homicide determine	building, e	tc. (Specify)	, (4111), 51	icot, idolory	r, omoc			City or To	own, Sta	ate)	nurari	noute warmber,
State  St		ospita hours unera ly fille		29a. Certifier 1 Certifying	Physician: To the best	of my knowle	dge, dea	th occurred	at the tin	ne, date an	d place, a	and due to th	e cause	(s) and manne	r as sta	ted.
State  St		the H nin 24 the Fi	ledio	one)	and manner si	tated.	Tana/or ii					ed at the time				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  STUDENT Jacobs mp 305 Jospit J M. Glen Burnie, mp 2106   State  31. Date filed (Month, Day, Year)  32. Registrar's Signature		To Vit	_	29b. Signature and title of certifier	10 1	2					23		-			-
State 31. Date filed (Month, Day, Year) 32. Registrar's Signature		, \		30. Name and address of nerson w	completed cause of	death (Item 29	Ba) (Type									
Cities	1	<u>t</u>		(free free land	obs mo	305		ospit	Q D	1. G	lan	Burni	Q,	mp a	10	6
					96	rar's Signatur		book)	9							

State of Maryland / Department of Health and Mental Hygiene 2007 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Month Year JOSEPH HOF 10:14AM M October 2007 /Medical 4a. Facilify Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner University of Maryland Medical Center Baltimore NIA If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** 1 X M 2 □ F Director 217-56-5896 July 7. 1950 Maryland Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a State 10b. Count 10d. Inside City Limits "natural", or items 23a or 28a-f show deal Examiner must be notified at Maryland Baltimore Baltimore 1 □Yes 2 N No Director 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? 6040 Cecil Avenue 21207 USA Pages 1 and 2 should be filed within 72 hours after death vent of Health and Mental Hygiene.
Init: If item 27 Is marked other than "natural", or items 23a mir; if item 21s marked other than "natural", or items 13ury or other traumatic event, the Medical Examiner must Funeral 11 Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: VietNam 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No White þ Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Sales 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Hof June Elizabeth Joseph Henry 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kathleen M. Hof (Wife) 6040 Cecil Ave., Baltimore, MD 21207 Department of Heatth Important: If item 27 any Injury or other troops. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Loudon Park Cemetery | 10/11/07 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Loudon Park Funeral Home 21. Signature of Funeral Service Licenses 3620 Wilkens Ave., Baltimore, MD 21229 23a. Part + Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** pneumonia 1 week /Medical Due to (or as a consequence of): Examiner 10 months non-Hodakins lymphoma Sequentially list conditions, if any, leading to infine diate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a sons quence of): Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): physician a the bunal-Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 4□Pregnant at time of death 9 I Inknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a Was an autopsy performed Yes 2 No 1☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Excertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) NP1:1265634166 October 7,2007 · Cecily Ms agrand, MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) , 22 S. Greene Street, Baltimore MD CECILY M.L. AGCAOILI 31. Date filed (Month, Day, Year) 32. Fistrar's Signature Registrar 2007 Thomas St.

**ORIGINAL** 

DHMH 17 Rev 1/2001

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Year 5, F. October 2007 2:45 p Richard Hupfeld 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Lorien Nursing Home Mt. Airy Carroll If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Maryland 8. Date of Birth (Month, Day, Dec. 27 5. Social Security Number 7. Age (In yrs. last birthday) X M 2 □ F Days Hours Min. Months 89 215-05-7916 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 Yes 2 No Maryland Baltiomre Parkville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2907 Andorra Court 21234 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 XX Yes 2 □ No WWII If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: 3 XWidowed 4 □ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Sales Manager Anheuser Busch 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Stanley Hupfeld Ethel Fahev 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Linda M. Barker / Niece 1111 Leafy Hollow Circle Mt. Airv. Md. 21771 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Denial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Most Holy Redeemer 10/10/07 Baltimore , Maryland 21. Signature of Funeral Cercice Licensee 22. Name and Address of Facility 1050 York Road Towson, Md. 21204 au Ruck Towson Funeral Home, Inc. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death eumonia with nevte Renal failure Immediate Cause (Final disease or condition resulting in death) WK Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 3 Ectopic pregnancy Day in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ➡No 3 ☐ Probably 4 ☐ Unknown anemia chime 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed Thoracic ANEUTY 2 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 1 ☐ Yes 2 No 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident

Examiner Examiner as the burial-transit Division of Vital Records. P.O. Box 68760. esn be detached for signed by page 2 has or Attending Physician: within 24 hours a To the Funeral C Medical

**Physician** 

/Medical

Examiner

Director

Funeral

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**Funeral** 

Director

item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Ever than the modified at

1 and 2 should be filed within Health and Mental Hygiene. em 27 Is marked other than \*

Department of Health and Important: If item 27 is many injury or other any injury or other

**Physician** /Medical

the Maryland

death with

Saltimore, Maryland 21215-0036

by Physician/Medical Completed Be Certification: To

27. Manner of Death

3 Suicide determined 4 Homicide

6 ☐ Could not be

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

base Ave, D-1 FREDERICK, Md.21101

31. Date filed (Morith, Day,

32 Registrar's Signature

DHMH 17 Rev 1/200

X

State Registrar

State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Norman С. Heller 10/07/07 12:45A M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Saint Joseph Medical Center Towson | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Feb. 25 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1**X** M 2 □ F Feb. 1923 Maryland 84 Director 220-18-6463 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any holury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 ☐ No Baltimore Timonium Maryland Directo 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 527 21093 USA Wyngate Road Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 1 Yes 2 No WW II 14. Race - American Indian Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2/☐ No White þ Specify: 3 X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Residencial&Commerical Contractor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Heller Flora Blanche Christ George Albert မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 527 Wyngate Road Timonium, Maryland 21093 Judy L. Heller / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Druid Ridge Cem. 10/11/07 Pikesville, Md. 21. Signatur Fun 22. Name and Address of Facility 1050 York Road Ruck Towson Funeral Home, Inc. Towson, Md. 21204 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart affure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. SELIST

Due to (or as a consequence of): Approximate Interval Between Onset and Death Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last Due to (or as a consequence of): Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of) Physician/Medical attending p for use as as IF FEMALE 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year Month 5 Other (specify) 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown ISCHEMIC CARDIOMYOPATHY 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No has e 2 page 2 1 No END STAGE RENAL DISEASE 1□ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 🔀 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D37254 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MARYLAND MD 76.01 32. Registrar's Signature OSLER TOWSON. 31. Date filed (Month, Day, Year) State OCT 0 9 2007 Registrar

Heller, Norman

Baltimore, Maryland 21215-0036

Box 68760

Division or Vital Records, P.O.

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month Jeanne 2:00 AM 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death TOWSON der 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) **Blakehurst** Baltimore If Under Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 ☐ M 2 🗑 F Yrs 87 May 16, 1920 Maryland <u> 213-18-1164</u> Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 ☐ No MD Baltimore Towson 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 1055 W. Joppa Road #431 21204 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: white 3 ₩idowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 0 homemaker own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Joseph Philip Ripley Wilhelmina Myers 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jeanne Thompson/daughter 18 Wincrest Drive Phoenixville, PA 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 N Donation 5 □ Other (Specify) 21. Sign tur 1 Funer Service Licenses 22. Name and Address of Facility

**Physician** /Medical Examiner

physician and s the burial-trans

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funeral director.

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To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director; After th completely filled in by the funeral

requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760,

**Physician** 

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Certification: To

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**Funeral** 

Director

7 is marked other than "natural", or Items 23a or 28a-f shor traumatic event, the Medical Examiner must be notified at

al Hygiene.

h and Mental h

Department of Health ar Important: If item 27 is any Injury or other trau

filed within 72 hours after

Pages 1 and 2 should be

3altimore, Maryland 21215-0036

Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

(or as a consequence of) Due to (or as a consequence of):

Director

Wade,

23a. Party. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate cause (Final disease or condition resulting in death)

a. Diseason or complications are caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, some cause (Final disease or condition resulting in death)

State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201

Onset and Death

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown

23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death 4☐Pregnant at time of death 9 Unknown

3 Ectopic pregnancy 5 Other (specify)

Month 23e. Did tobacco use contribute to the cause of death?

23d Date of delivery

1 Yes 2 No 3 Probably 4 Unknown

contributing to death but not resulting in the underlying cause given in Part I.

Ronald S.

24a. Was an autopsy performed 1□ Yes

26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

Day

Year

25. Was case referred to medical examiner? 1 Yes 2 No 27. Mann of Death

5 Pending investigation 6 Could not be

28a. Date of Injury (Month, Day Year)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of Injury

Other: 4 Nursing Home 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

5 ☐ Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only

2 Accident

3 ☐ Suicide

4 Homicide

and manner stated

BUTIMORES

. Name and address of person who completed cap of death (Item 23a) (Type, Print) Compan C 6/01

MA Day, OCT 0.9 2007

29b. Signature and title of certifier

Registrar's Signature

N CHARLES

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			For State Registrar	State of Ma		partment of I e <i>rtificate of</i>			giene leg. No.2 ()	0.7	32191
Ş.		III)	Hegistrar     Decedent's Name (First, Middle)	dle, Last)		Crimoato or	Douth	2. Date of Dea	ith		3. Time of Death
	Physicia /Medic		Edwin Hender	rson				Septemb	er 24,	2007 1	11:25 AM™
	Examin		4a. Facility Name (If not institution	on, give street and number)		4b. City, Town,	or Location of Death	-	4c. Count	y of Death	
		vs.		Health & Reh			n Burnie			Arunde	
	Funeral Director		5. Social Security Number 214–26–2740	6. Sex 7. Ag-	e (In yrs. last birthda 77 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day July 30	(, Year)	9. Birthplac Country	ce (State or Foreign v) unk
	land		Usual Residence of Decedent  10a. State 10b. Count	у	10c. City, Town or	Location				10d	I. Inside City Limits
	Mary -f sho	tor	MD Anne	Arundel	G1en	Burnie					1 ☐ Yes 2 ☐ No
	r 28a	irec	10e. Street and Number			10f. Zip Code			10g. Citizen of	What Country	l's
	h with	a D	7575 E. Howard	d Road			21060		Ţ	JSA	
20	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If them 27 is marked other than "natural" or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Ma 3 ☒ Widowed 4 □ Divorce	If Yes Give	Ever in U.S. 1	3. Was Decedent of I If Yes, specify Cub 1 ☐ Yes 2 ☒ No		pecify Yes or No- Rican, etc.)	14. Ra Bla Speci	ce - American ick, White, etc fy: Whi	c.
Ş	hour tural		24	ent's Education	16a. De	cedent's Usual Occu	pation	unk	16b. Kind of E	Rusiness/Indus	stry un
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2 2	ld be file lental Hy ked othe Ic event	To Be (	17. Father's Name (First, Middle	e, Last)		unk	18. Mother's Nam	e (First, Middle,	Maiden Surna	me)	unk
	2 should I and Men is marker aumatic e	-	19a. Informant's Name/Relation	ship (Type. Print)	19b. Ma	uiling Address (Street	t and Number or Ru	ral Route Numbe	r, City or Town	, State, Zip C	rode)
.,	and lealth m 27 her tr		Marley Neck He	ealth & Rehab		E. Howar				21060	
	Pages 1 nent of H int: If ite		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 📆 Other (		20b. Place of Dis	position (Name of rematory or other pla		Date	20c. Location	- City or Towr	ı, State
ספור	permit. Departin Importa any inju		21. Sign to of Funeral Prvice Ronald	e Licens e		22. Name and Addr State Anat Baltimore,			Baltim	ore St	reet
	Dhi.i.i	0.1	23a. Part1. Enter the disease, of shock, or heart failure. List Immediate Cause (Final	or complications that caused st only one cause on each lin	the death. Do not ene.	enter the mode of dy	ing, such as cardiac	or respiratory arr	VASC	ULAR	proximate erval Between set and Death
	Physician /Medical Examiner		disease or condition resulting in death)	a. Due to (or as	a consequence of):	1011	NOF	D.O.	ISEA	SE (	SYEAP
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700	ng ph	Med	IF FEMALE:	1							
	e Hospital or Attending Physician: The law requires that the death certificate be executed 12 Hours after death.  The Funeral Director: After this certificate has been signed by the attending physician and 18 Euneral Director; After this certificate has been signed by the attending physician and letely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medica	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1□Live birth 4□Pregnant at 9□Unknown	2 ☐ Fetal death	3 □Ectopic pregnanc 5 □ Other <i>(sp</i> ec <i>ify)</i> _	су		(4)	ate of delivery onth Da	
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	he law require e has been sig ige 2 should b	Completed						24a. Was a autop:	sy	Were autops prior to comp death?	y findings available pletion of cause of
9	an: T tifficate or, pa		25. Was case referred to medic	al			26. Place of Deal		212No	1 ☐ Yes 2	□ No
>	ysicia is cer direct	o Be	examiner? 1 ☐ Yes No	Hospital: 1 ☐ Inpatie	nt 2 ER/Outpat	ient 3 DOA Ot	her:	ome 5 ☐ Resid		her (Specify)	-
5	iding Physician: The lav h. • After this certificate has i funeral director, page 2 !	tion: T	27. Mann of Death  1 atural 5 Pendinves	28a. Date of Inju ing (Month, Day tigation	ry 28b. Time	of 28c. Inju		28d. Describe h		- ' ' - ' - '	
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	ne Hospital	dical C		ing Physician: To the best of all Examiner: On the basis of and manner sta	examination and/or						

To the Hos within 24 hd To the Fun completely

State Registrar

29b. Signature

31. Date filed (Month, Dat, Dat) 1 0 0 0 7 0 9 2007

		Plea	se Type or Print i						egible.	
		For State Registrar	State of Mary		rtment of F tificate of		Mental Hy	giene Reg. No	007	32192
		Decedent's Name (First, Middle	e, Last)				2. Date of D	-	Year	3. Time of Death
Physicia /Medic		DOROTHY		НС	BERMAN		10	4	2007	12.18 PM
Examin	er	4a. Facility Name (If not institution				r Location of Death		4c. (	County of Death	
		Sinai Hosp  5. Social Security Number	6. Sex 7. Age (In	yrs. last birthday)	Balf n	If Under 24 Hrs.	8. Date of Bi	rth	N/A 9. Birthold	ace (State or Foreign
Funeral Director		012-14-8209 Usual Residence of Decedent	1□M 2 <b>X</b> )F 8		Months Days	Hours Min.	(Month. D	ay, Year) 7/191	Count	CT
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	tor	10a. State 10b. County  MD BAL	TIMORE	c. City, Town or Loc  BALTIMOR					10	d. Inside City Limits 1 ☐ Yes 2 No
th the or 28a e noti	Director	10e. Street and Number		011211101	10f. Zip Code			10g. Citiz	en of What Count	ry?
23a ust b		1840 REISTERST			21	1208			USA	
er dea items	Funeral	11. Marital Status	12. Was Decedent Ever Armed Forces?	r in U.S. 13. W	as Decedent of H Yes, specify Cub	lispanic Origin? (Sp an, Mexican, Puert	pecify Yes or N o Rican, etc.)	0- 1	<ol> <li>Race - America Black, White, e</li> </ol>	
irs aft ir, or xami	by	1 Never Married 2 Marr 3 Widowed 4 Divorced	ied 1 □ Yes 2 🗶 No If Yes, Give Year or Dates:	1	□Yes 2XX No	Specify:			Specify: WHI	ΓΕ
2 hou latura ical E	ted	15. Deceden			ent's Usual Occup		tota	16b. Kin	d of Business/Ind	ıstry
within 7 iene. than "r the Med	Completed	(Specify only higher Elementary/Secondary (0-12)	College (1-4or 5+)	life. D	OWNER	during most of word d)	King	JEWE	LRY STO	RF
e filed Il Hyg other	BeC	17. Father's Name (First, Middle,	Last)		J	18. Mother's Nam	ne (First, Middle			
should be ind Mental inarked o martic eve	10 8	ABRAHAM		E	GER	CLARA			Е	LLOVICH
2 sho l and l is ma		19a. Informant's Name/Relations		1 '	•	and Number or Ru				
1 and Health em 27 ther tr		PHYLLIS KOLM		76 KI		CIRCLE,	BALIIM		MD 2120 sation - City or Tov	<del></del>
Pages nent of h int: if Ite iry or of		1 Burial 2 Cremation	3 □Removal from State	cemetery, crem	atory or other pla				-	
nit. P artme ortani Injury		4 □ Donation 5 □ Other (S 21. Signature of Funeral Service		BALTIMORE 22.	Name and Addre				EISTERST(	
permit. Depart Import any Inj once,		Matt Le				STERSTOWN			& BROS.,	INC. MD 21208
		23a. Part1. Enter the disease, or shock, or heart failure. List	complications that caused the only one cause on each line.							Approximate Interval Between
Physician		Immediate Cause (Final disease or condition	Intra C	erebello	ir Ble	ed				Onset and Death  H days
/Medical Examiner		resulting in death)	Due to (or as a co	nsequence of):						
	<u>-</u>	Sequentially list conditions, if any, leading to immediate	b	nsequence of):						
a AVE	xaminer	Cause (Disease or injury that initiated events		1						
executed an and rial-transit	Еха	resulting in death) Last	Due to (or as a co	nsequence of):		-				
ficate be ex physician s the burial	ical		d							
ertifica ling ph e as t	Med	IF FEMALE:		— Arvelluit						
To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physicia completely filled in by the funeral director, page 2 should be detached for use as the bur	Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown	23c. If yes, outcome pf p 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3	Ectopic pregnanc Other (specify) _	у		2	3d. Date of deliver Month I	y Day Year
that the	Y Ph	Part II. Other significant condition	ons contributing to death but no	ot resulting in the un	derlying cause giv	en in Part I.	23e. Did	tobacco us	se contribute to the	cause of death?
w requires been sign should be	ed by	Depression	, GERD,	Hypoth	yroidis	m	1	Yes 2	No 3☐ Proba	ibly 4 Unknown
aw re	Completed	Multiple B	ack suger				24a. Wa		24b. Were autop	sy findings available
The I	E		0					opsy formed? 2 No	death?	pletion of cause of 2 □ No
sician: The law s certificate has b irector, page 2 s	Be (	25. Was case referred to medica examiner?				26. Place of Dea				
Physic this c	۵,	1 Yes 2 No	Hospital: 1 Inpatient	2 ER/Outpatient	3 DOA				□Other (Specify	)
ding Phys h. After this funeral dir	ion	27. Manner of Death  1 Natural 5 Pendin  2 Accident investig		28b. Time of Injury	28c. Inju Wor M 1 □	ry at rk?  Yes 2 ∐ No	28d. Describe	how injury	occurred	
Attendest death sctor: y the	ficat	3 Suicide 6 Could	not be 28e. Place of injury -	At home, farm, stre		1100 2 110	28f. Location	(Street and	f Number or Rural	Route Number,
al or / s after il Dire	Certification:	4 ☐ Homicide determ	building, etc. (S	Specify)			City or To	own, State)		
To the Hospital or Attend within 24 hours after death To the Funeral Director: , completely filled in by the f	Medical (	29a. Certifier 1 Certifylr (Check only one)	ng Physician; To the best of m Examiner: On the basis of exa and manner stated.	amination and/or inv	occurred at the ti	me, date and place opinion, death occu	e, and due to the irred at the time	e cause(s) e, date and	and manner as sta place, and due to	ated. the cause(s)
To th within To th	Me	29b. Signature and title of certifie	-		29c. Licens			29d. Date	e signed (Month, L	Pay, Year)
		> Leave	as MD		Dog	061558	5	Oct	4,20	07
6		30. Name and address of person	who completed cause of death	(Item 23a) (Type, F	Print)		0 -			
)		FALGUNI PAR	IKH , ND ;	750 MA Signature	N 3T,	REISTE	KSTON	らら	MDS	-1136
Sta Registr		31. Date filed (Month, Day, Year)	2007 32 Registrar's	Signature	and I					

			1 - State of Marylan		epartment of F Dertificate of		fental Hy	giene 0 0	7 32193
			Decedent's Name (First, Middle, Last)				2. Date of D	eath	3. Time of Death
	Physic /Medi		ANDREW JACKSON, JR.				Octob	oer by, ?	ZONT IN: 30PM
	Exami		4a. Facility Name (If not institution, give street and number)		an a 0	or Location of Death		4c. County of	10- /2
			BALTIMORE WASHINGTON MEDICAL CE			If Under 24 Hrs.	e .	Hynn	
	Funeral Director		5. Social Security Number 6. Sex 1 M 2 F 90	iast σίπης Yr	Months Days	Hours Min.	8. Date of Bi (Month, D JULY 1	Nay, Year)	Birthplace (State or Foreign Country)  IARYLAND
			Usual Residence of Decedent				JOHI I	1717 11	AKTLAND
	r 28a-f ehow	lu			or Location				10d. Inside City Limits
	88-1	Director		ADEN					1 ☐ Yes 2 X No
	with the		10e. Street and Number		10f. Zip Code			10g. Citizen of Wh.	ŕ
	death w	Funeral	1808 FOXBERRY LANE, APT. 1505  11. Marital Status 12. Was Decedent Ever in U	.S.	21122	Hispanic Origin? (Sp	ectfv Yes or N	UNITED S	STATES American Indian,
	after of	Ξ	Armed Forces? 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☒ No		If Yes, specify Cub	an, Mexican, Puerto	Rican, etc.)	Black,	White, etc.
	ours a	b	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:		1 ☐ Yes 2X No	Specify:		Specify:	WHITE
	21215-0036 of within 72 hours aft glene. or than "naturel, or	Completed	15. Decedent's Education (Specify only highest grade completed)	(0	ecedent's Usual Occur Give kind of work done	during most of work	ing	16b. Kind of Busin	ness/Industry
	2121 1 within glene. r than	g	Elementary/Secondary (0-12) College (1-4or 5+)		fe. <i>DO NOT u</i> se retire CTRICIAN	a)		BUILDIN	IC
	be filed trail Hygin of other		17. Father's Name (First, Middle, Last)		01111011111	18. Mother's Nam	e (First, Middle	e, Maiden Sumame)	
	fan lid be fental rked	To Be	ANDREW JACKSON, SR.			CAMSADEL	HAMMON	ID	
	Maryland 21215-0036 d 2 should be filed within 72 hours after death with the Maryland th and Mental Hyglene. Z7 is marked other than "natural", or iteme 23s or 28s-1 show treumatic event, the Mudical Examinar must be cotilled at	-	19a. Informant's Name/Relationship (Type, Print)	19b. N	failing Address (Street	and Number or Rur	al Route Numb	ber, City or Town, St	ate, Zip Code)
	end 2 ealth in 27 is		JAMES JACKSON / SON	-	MILBURN CI	R., PASAD	ENA, MA	RYLAND 21	122
	Baltimore, bermit. Pages 1 er Depertment of Hea mportant: if Item my injury or othe		20a. Method of Disposition  1 ☒ Purial 2 ☐ Cremation 3 ☐ Removal from State	Place of D semetery,	isposition (Name of crematory or other pla	1 000		20c. Location - Ci	ty or Town, State
	timentant:		4 Donation 5 Other (Specify) GLI	EN HA	VEN MEM. P				NIE, MARYLAND
	Baltimore, Mispermit Pages 1 end 2 Department of Health a Important: If Item 27 is eny Injury or other tre		21. Signative of Fune, I Service Licensee		KIRKLEY-RI 421 CRAIN	JDDICK FUI HWY., S.1	NERAL H	OME, P.A. IN BURNIE,	MD 21061
			23a. Part 1. Enter the disease, or complications that caused the deat shock, or heart failure. List only one cause on each line.	h. Do no	t enter the mode of dyin	ng, such as cardiac	or respiratory	arrest,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)	cti	Som X	)nehr	non	14	Onset and Death
	/Medical Examiner		Due to (or all a conseq	uence of)	2/10				
13	المصلة	10	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence)	uence of)	V /				
3	ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	20	1 co	meer			
2	58760, icate be exebblised physicien and s the burial-transit	Exa	resulting in death) Last Due to (or as a conseq	uence of)	•				
3	8760 cate be e	dical	d.						
10	K 65	Med	IF FEMALE:						
( )	Records, P.O. Box 68760, The law requires that the death certificate be executed the has been signed by the ettending physicien and bage 2 should be detached for use as the burial-transit	Physician/Me	23b. Was decedent pregnant in the past 12 months?	l death	3 ☐ Ectopic pregnance	у		23d. Date of Month	-
	P.O. that the de ed by the detached	ysic	1 Yes 2 No 4 Pregnant at time of d	eatn	5 Other (specify)				
2 .	that the ode by detac		Part II. Other significant conditions contributing to death but not res	ulting in th	ne underlying cause giv	(en in Part√.	23e. Did	tobacco use contribu	ute to the cause of death?
3.	rds, quires t	d by	156287081S, H	trì	5/ 5	prillsto	10	Yes 2 □No 3	Probably 4 Unknown
- 6	ecord law requir as been si 2 should la	Completed			,		24a. Was	s an 24b. We	ere autopsy findings available
8	The li	E					auto perf 1 ☐ Yes	formed? dea	or to completion of cause of ath?
5	Vital F sician: Th certificete irector, pag	Bec	25. Was case referred to medical examiner?			26. Place of Deat	h Check only	one)	
J.	Of V Physic rithis corral dire	ို	1 Yes 2 No Hospital: 1 Inpatient 2	ER/Outp	atient 3 DOA Ott	ner: 4 Nursing Ho		sidence 6 Other	
	On O	lon	27. Manner of Death  1 Substural 5 ☐ Pending (Month, Day Year)	28b. Tin Inju	iry Wo	ryat rk? Yes 2 □ No	28d. Describe	how injury occurred	
	Division  or Attending after death. Director: Afte	licat	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At h	ome farm		Tes ZUNO	28f. Location	(Street and Number	or Rural Route Number,
i	Division at or Attend as after death by Director	Certification:	4 Homicide determined building, etc. (Specif	y)	, street, lactory, office		City or To	own, State)	or marar rissis warrisor,
	Division of Vita within 24 hours after death.  To the Funerel Director: After this certific completely filled in by the funeral director.	Medicai	29a. Certifier (Check only one) Certifying Physicien: To the best of my knot 2 Medical Examiner: On the basis of examina and manner stated.	wledge, o	death occurred at the til or investigation, in my o	me, date and place, opinion, death occur	and due to the red at the time	e cause(s) and mann , date and place, and	er as stated. d due to the cause(s)
	To th withir To th	W	29b. Signature and little of certifier m2		29c. Licens	se number		29d. Date signed (	Month, Day, Year)
	$\sim$				174	8000		10/04/2	207
	30		30. Name and address of person who/completed cause of death (Iten	n 23a) (T)	HVD)	ta) >	C-, C	Jim B.	hrnit, m)
	Sta Regist		31. Date filed (Month, Day, Year)  OCT 0 9 2007	ture	Smeath !		/		,
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No 2 [ ] Certificate of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) Month 200 **Physician** 3:00 /Medical Aity, Town, or Location of Death 4c. County of Death acility Name (If not institution, give street and number) **Examiner** VindAL 9. Birthplace (State or Foreign Social Security Number **Funeral** Year Days 1 M 2 W 220-01-689 Usual Residence of Decedent Director -688 Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Intern 27 Is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County "natural", or items 23a or 28a-f show dival Examiner must be notified at 1 Pres 2 No Director AttimoRE L 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 8 1504 2 nwood Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race American Indian, Black, White, etc. 12. Was Decedent Eyer in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 2 No 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Baltimore, Maryland 21215-0036 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) other traumatic event, the Medical College (1-4or 5+) Elementary/Secondary (0-12) stodian 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Be ٩ 19b. Mailing Address (Street and Number or Rugal Route Number, City or Town, State Zo Code 19a. Informant's Name/Relationship (Type. Print) SRENdA 20b. Place of Disposition (Name of cemetery, crematory or other Date 20g 20a. Method of Disposition permit. Pages 1
Department of F
Important: If Ite
any Injury or ot 1 Bunal 2 □ Cremation 3 □ Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee SRO AdulA caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, each line. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that shock, or heart failure. List only one cause of Immediate Cause (Final Sepsis 12 hours Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner and burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical as the ed by the attending detached for use as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 No 5 Other (specify) 9 I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ wounds dysphagia 1 TYes 2 X No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? contractures 24a. Was an urinary autopsy performed? 1□ Yes 2 No indewelling catheter death? 1 ☐ Yes chronic foley with 2 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? completely filled in by the funeral director, Be 26. Place of Death (Check only one) Hospital: Other: 2 No 1 Inpatient 1 🗌 Yes 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) ٩ after death. Director: After this 28a. Date of Injury 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: (Month, Day Year) 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a To the Funeral C Xcertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of partifier MD D0053928 10/05 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SURATYA BERUM, 2434 WIBELVEDERE AVE, BALTIMORE, MN-21215 strar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

OCT 0 9

2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death October 1, 2007 Ella Beatrice Jones 3:35 A M 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death 2803 Florida Avenue Baltimore Baltimore If Under 1 Year | If Under 24 Hrs Months Days Hours | Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Jan. 29, 1944 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1□ M 24 F Virgin<u>ia</u> 219-38-7124 63 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2X No MD Baltimore N/A 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2803 Florida Avenue 21227 United States . Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 Married 1 ☐ Yes 2 XNo Specify: White Specify: 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Security Officer Security 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Frank G. Shaw Trula V. Handy 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Roy A. Jones - Husband 2803 Florida Avenue, Baltimore, MD 21227 20a. Method of Disposition Date 20b. Place of Disposition (Name of 20c. Location - City or Town, State Bell All Memorial 1 X Burial 2 □ Cremation 3 □ RemovaLfrom State 4 ☐ Donation 5 ☐ Other (Specify) Oct. 5, 2007 Bel Air, Maryland Gardens Ambrose Funeral Home of Lansdowne 2719 Hammonds Ferry Rd. Lansdowne MD 21. Si ma ure of Funeçal Şe 21227 23a. Part1. Enter the disease shock, or heart failure. Approximate Interval Between Onset and Death or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Bowle Immediate Cause (Final 3 weeks disease or condition resulting in death) Due to (or as a consequence of) ancer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9□Unknown 9 Hlnknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?

Physician /Medical Examiner

**Physician** 

/Medical

Examiner

10a. State

Funeral

Director

r 28a-f show notified at

or be with

"natural", or items 23a

permit. Pages 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23, any injury or other traumatic event, the Medical Examiner must

Baltimore, Maryland 21215-0036

Director

Funeral

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Completed

Be

the Manyland

physician and the burial-trans attending p signed by the a d be detached f funeral

Hospital or Attending Physician: The law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760,

Examine Physician/Medical þ Be Completed Medical Certification: To within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

			1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown
			24a. Was an autopsy performed?  1
25. Was case referred to medical examiner?		26. Place of De	ath (Check only one)
1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3	Other: 4 Nursing F	Home 5 PAesidence 6 □Other (Specify)
27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	'	28c. Injury at Work? M 1 ☐ Yes 2 ☐ No	28d. Describe how injury occurred
3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of injury - At home, farm, street, building, etc. (Specify)	factory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)
			e, and due to the cause(s) and manner as stated. urred at the time, date and place, and due to the cause(s)
29b. Signature and title of certifier	OM.	29c. License number	29d. Date signed (Month, Day, Year)
I Jeffrey Lance	Magaymen MD	D00219	49 October 1, 2007
30. Name and address of person who	completed cause of death (item 23a) (Type, Prin	t)	111 11 12 24.55
Jettrev Lance	Magaziner, 1075	S Falk Road,	Whereille MD 21093
31. Date filed (Month, Day, Year)	32. Registrar's Signature		/
OCT <b>0 9</b> 2007	Menya D. Sporte		

State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2007 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year -111 3:57 p<sup>M</sup> October | 5 2007 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 1302 E. SPRINGMEDOW CT **EDGEWOOD** HARFORD CO If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday, 1 □ M 2 🕅 F Vrs 53 Nov. 8 1953 MARYLAND 212-62-5015 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10h. County 10d. Inside City Limits 1 ☐ Yes 2 No MARYLAND HARFORD CO **EDGEWOOD** 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1302 E. SPRINGMEADOW CT. 21040 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2X No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes ŽŽNo Specify. Specify: BLACK 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th grade GOVERNMENT SUPPLY CLERK (TECH) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) PAUL LESTER ATHALENE M. LESTER 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ervin Lester/ Brother 316 George St., Belair, Maryland 21014 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 □Removal from State 4 □ Donation 5 □ Offier (Specify) HIGHVIEW MEM. GRDNS 10-20-2007 BELAIR, MARYLAND 21. Signature of Fundal/Salvar Links 22 Name and Address of Facility
WM C BROWN COMM FUNERAL HOME-HARFORD, P.A.
321 S PHILADELPHIA BLVD., ABERDEEN, MD 21001 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. no tocillular Carcinoma

Physician /Medical Examiner

**Physician** 

/Medical

Examiner

Directo

Funeral

Completed by

Be

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**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

burial-tran as nse ó ed by the a detached f ate has been signe page 2 should be

Division or Vital Records, P.O. Box 68760

or Attending Physician:

To the Hospital

2 Be funeral within 24 hours after death.

To the Funeral Director: Aft

29b Signature and title of certifie

31. Date filed (Month, Day, Year)

Ŀ	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequence of):	6	_		(	Dyeans
dical Examiner	Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c					
by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	23c. If yes, outcome pf pregnancy  1 Live birth 2 Fetal death 3 4 Pregnant at time of death 5 9 Unknown	]Ectopic pr ] Other <i>(sp</i>	egnancy ecify)	_	23d. Date of delive Month	ery Day Year
ted by Pł	Part II. Other significant conditions of	contributing to death but not resulting in the ur	nderlying ca	ause given in Part I.		o use contribute to ti 2⊈ No 3 ☐ Prot	he cause of death? pably 4 □Unknown
Completed	7 7				24a. Was an autopsy performed 1☐ Yes 2X	prior to co death?	ppsy findings available mpletion of cause of
Be	25. Was case referred to medical examiner?			26. Place of De	ath (Check only one)		
<b>7</b> 0E	1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatien	t 3□ DO	Other: 4 Nursing I	Home 5 Residence	6 ☐Other (Special	60)
ation:	27. Manner of Death  1 Natural 5 ☐ Pending 2 ☐ Accident investigation		M 2	8c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how in	jury occurred	
Medical Certification:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined		eet, factory	r, office	28f. Location (Street City or Town, St.	and Number or Rura ate)	al Route Number,
edical (	29a. Certifier 1. Certifying Ph (Check only one) 2 Medical Example 1	ysician: To the best of my knowledge, death hiner: On the basis of examination and/or in and manner stated.	n occurred vestigation	at the time, date and place, in my opinion, death occ	e, and due to the cause urred at the time, date	e(s) and manner as s and place, and due t	stated. o the cause(s)
M	29h/Signature and title of certified		290	. License number	29d. [	Date signed (Month	Day, Year)

29c. License number

State Registrar

busnes

of person who completed cause of death (Item 23a) (Type, Print)

308

32. Ragistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** nson Corgia 200 octobe /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N timore Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) . Age (In yrs. last birthday) **Funeral** Months Days Hours 1 □ M 2 2 E Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the M dical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Yes 2□No Funeral Director 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. □ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify: 10 Specify: Be Completed by 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NQT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) House 6th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Ian 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) caughte 1028 Bennett Ellens *7*00 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Sremation 3 ☐ Removal from State 4 □ Donation 5 ☐ Other (Specify) uneral Suvice/Lic 22. Name and Address of Ficility 21. Signature of trineral Approximate Interval Between Onset and Death 23a. Part I. Enter the the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, reart failure. List only one is use on each line. shock, of Immediate se (Final disease or condition resulting in death) **Physician** Intestina /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of). or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, **unector:** After this certificate has been signed by the attending physician I in by the funeral director, page 2 should be detached for use as the buria Completed by Physician/Medical If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 4 Inknown 1 Yes 2 No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2□No 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 ☐ NO Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Impatient 2 ER/Outpatient 3□ DOA Medical Certification: To 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No To the Hospital or Attend within 24 hours after death. To the Funeral Director: 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 🔛 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ober 6, 2007 f death (Item 23a) (Type, Print) 30. Name and address of person who completed cause 0/0

State Registrar 31. Date filed (Month, Day,

DHMH 17 Rev 1/2001

ORIGINAL

32: Registrar's Signature

The law requires that the death certificate be executed and / burial-trar Division or Vital Records, P.O. Box 68760 attending physician for use as the buria signed by 1 I be detact funeral director, Director: filled in by

10:00 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 7601 Bayside Avenue Fort Howard Baltimore If Under 1 Year If Under 24 Hrs.
Months | Days | Hours | Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) NOV 17, 19 6. Sex 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) **Funeral** Days Months 1**X** M 2□ F 57 1949 Director 214-50-4844 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
ant: If Item 27 is marked other than "natural", or items 23a or 28a-f show ant: If item 27 is marked other than "natural", or items 25a or 28a-f show ant. If other traumatic event, the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Directo MD Baltimore Fort Howard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7601 Bayside Avenue 21052 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify Specify: δ 3 ☐ Widowed 4 X Divorced Year or Dates: White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) Firefighter Bethlehem Steel 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Maurice Eugene ပ Jones Dolores Williams 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Maurica L. Marcum, daughter 2406 Cooper Avenue Sparrows Point, MD 21219 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Pages 1
Department of H
Important: If ite
any injury or ott 1 ☐ Burial 2 X Cremation 3 □Removal from State 4 Donation 5 Dother (Specify) Metro Crematory, Inc. 10/09/07 Baltimore, MD 21. Signature of Funeral Service Licensee George MacNabb 22. Name and Address of Facility Cremation Society of MD, Inc. 299 Frederick Road Baltimore, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Asthma /Medical Due to (or as a consequence of): **Examiner** astritis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine anemia Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş 1 | Yes 2 | No 3 | Probably 4 | Unknown certificate has been s rector, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? res 2 No 21 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home ို 1 Yes 2 No 5 ■ Residence 6 □ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) delas D0044271 October 8, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Daniel H. Collector, 35 E. Padonia Road M.D.Timonium, MD 21093 31. Date filed (Month, Day, Year) 82. Registrar's Signature State Registrar OCT 0 9 2007

State of Maryland / Department of Health and Mental Hygie 10 7 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month <sup>Day</sup> 2007 **Physician** 29, 1:30 P M Arlin Haywood Johnson /Medical 4c. County of Death 4e. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Fort Washington

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Prince George's Fort Washington Hospital Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months Days 1 ☐ M 2 ☐ F Yrs. Director <u>323 24 5438</u> 76 July 21, 1931 | Chicago, Ill Usuel Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f ahow the Medical Examiner must be notified at 1 Yes 2 No Temple Hills Prince George's Directo Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number or Items 23a or 5200 Redd Lane 20748 United States Funeral 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give XX Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes XX No Specify: Completed by 3 ☐ Widowed 4 ☐ Pivorced "natural" Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry than Elementary/Secondary (0-12) College (1-4or 5+) CPA permit. Pages 1 and 2 should be filed v
Department of Health and Mental Hygie
Important: If item 27 is marked other 11
any injury or other traumatic event, IIIA
ODGE. 4 Accountant other 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Alvin H. Johnson, Sr. Amv French 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Arlin D. Johnson Ramsey (Son) 14219 Drexel Ave, Dalton, Ill 60419 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition 1 ☐ Burial 2 XX remation 3 ☐ Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) Lee Crematory Oct 3, 2007 Clinton, MD 21. Signatore, of Fineral Servica Light 22. Name and Address of Facility Lee Funeral Home, Inc 6633 01d Alexandria Ferry Road, Clinton, MD Approximate Interval Between Onset and Death 23a. Part1. Enter the diseas shock, or heart failure or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. diseas Immediate Cause (Final disease or condition resulting in death) Danmon Cell Carunomy **Physician** /Medical Due to (or as a consequence of). **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physicien and for use as the burial-transit Due to (or as a consequence of): Box 68760 Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy Month Dav Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an 1 Yes 2 110 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 Matural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu investigation 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 T Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and Walf or rifler 29d. Date signed (Month, Day, Year) D0055120 29 207 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) Kalmer MD 1328 Southern avenue SE Snite 310 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 0 9 2007 Registrar

DHMH 17 Rev 1/2001

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month R. Johnson Sr. OCTOBER 2007 05 4b. City, Town, or Location of Death 4c. County of Death HOSPITAL BALTIMORE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday, 1 M 2 □ F Months Days Hours Min. 76 May 15, 1931 Virginia

1. Decedent's Name (First, Middle, Last) **Physician** 3-00 AM Marshall /Medical 4a. Facility Name (If not institution, give street and number) Examiner SAINT AGNES 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Director 219-28-8957 Usual Residence of Decedent 10c. City, Town or Location a or 28a-f show t be notified at 10a. State Md . 10b. County 10d. Inside City Limits 1 Ves 2 No === Baltimore City Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. "natural", or items 23a 1600 Inverness Avenue 21230 **Examiner must** Funeral within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Machinist Factory d 2 should be filed with and Mental Hygier 7 is marked other the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles Johnson, Sr. Margaret Clifton ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2: Department of Health ar Important: If item 27 Is any injury or other trau 1600 Inverness Ave. Balto. Md. Shari Johnson, daughter 21230 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 □ Cremation 3 □ Removal from State Md. Veteran Cemetery 10/12/07 Crownsville, Md. 4 ☐ Donation 5 ☐ Other (Specify) ur of Funeral Service Licensee 22. Name and Address of Facility Gonce Funeral Service P.A. 4001 Ritchie Hgwy. Baltimore, Md. 21225 remerouske 23a. Part1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Ust only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician ASPIRATION PNEUMONIA /Medical Due to (or as a consequence of): Examiner LUNG ADENO CARCINOMA Sequentially list conditions, Dus to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine BRAIN METASTASIS TO attending physician and for use as the burial-trar Due to (or as a consequence of): pe Physician/Medical RADIATION TO BRAIN MARSHALL R. I Records, P.O. Box IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month 5 ☐ Other (specify) signed by the ☐Yes 2☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? LOHNSON , といれられい Division or Vital Records, þ CORONARY ARTERY DISEASE 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an cate has by page 2 s autopsv perform certificate 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 this 28a. Date of Injury 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After t completely filled in by the funera Medical Certification: or Attending (Month, Day 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) admixa P20659 MD OCTUBER 05, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 900 CATON AVENUE, BALTIMORE, RADHIKA KALISETTI, MD MD 21229 31. Date filed (Month, Day, Year) 32. Registrar's Signature

Registrar

OCT 0 9 2007

JOHNSON

			1 _ State		artment of Health and rtificate of Death		iene 9. No. 2007	32201
			Registrar  1. Decedent's Name (First, Middle, Last)	061	incate of Death	2. Date of Deat	h	3. Time of Death
	Physicia /Medic		Carolle Anne	October	6, 2007 Year	3:35 P M		
100	Examin		4a. Facility Name (If not institution, give street and number)	ath	4c. County of Death			
			Stella Maris Hospice  5. Social Security Number 6. Sex 7. Age (In yrs	. last birthday)	Timonium If Under 1 Year   If Under 24 H	rs. 8. Date of Birth	Balti	
15-1	Funeral Director		067-70-3005   1	16	Months Days Hours Mi		Year) 9. Birti Coi 2 1970   [1]	pplace (State or Foreign intry) inois
	ъ		Usual Residence of Decedent			эсре. г	2,1570 111	
	arylar show	'n		ity, Town or Lo				10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	the M 28a-f notifie	recto	Maryland Baltimore	Hunt Va	10f. Zip Code	10	Og. Citizen of What Cou	
	3a or	Funeral Director	13 Forwood Court		21030		U.S.A.	
	deatl	iner	11. Marital Status 12. Was Decedent Ever in Armed Forces?	J.S. 13.	Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pu	(Specify Yes or No-	14. Race - Amer Black, White	
36	s after	by Fu	1  Never Married 2 Married 1  Yes 2 M No If Yes, Give 3  Widowed 4  Divorced 1  Yes 7  Year or Dates:	1	1 □ Yes 2 □ <b>X</b> No <i>Specify:</i>	, , , , , , ,	Specify:	
21215-0036	72 hours after death with the Maryland natural", or items 23a or 23a-f show dical Examiner must be notified at	ed b	15. Decedent's Education	16a. Dece	dent's Usual Occupation		16b. Kind of Business/I	White ndustry
215	thin 7; e. an "n Medi	Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)	1	kind of work done during most of v DO NOT use retired)	vorking		
121	led wi lygien <b>her th</b> nt, the	Co	17. Father's Name (First, Middle, Last)		Homemaker 18 Mother's N	ame (First, Middle, M	Own Home	
Maryland	d be fi ental F ced ot c ever	) Be	William Conway			erly	0'Brochta	
aryl	shoul ind Ma s marl umati	۲	19a. Informant's Name/Relationship (Type. Print)	19b. Mailir	ng Address (Street and Number or			ip Code)
	and 2 salth a n 27 is er tra		Robert Jacapraro Husband	13 F	orwood Court H	lunt Valley	, Maryland	21030
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition  1 🛣 Burial 2 □ Cremation 3 □ Removal from State	Place of Dispo	sition (Name of natory or other place)	Date 2	20c. Location - City or 1	Γown, State
亞	it. Paritmen rtant: njury		4 Donation '5 Other (Specify)  21. Salature of Eunekal Servica Litrensee	Memori	valley al Gardens 10- 2. Name and Address of Facility		Timonium	Maryland
Ba	permi Depar Impor any ir		Town to take an		1050 York Road		on Funeral Maryland 21	
9			23a. Part1. Enter the disease, or complications that caused the des shock, or heart failure. List only only cause on each line.	ath. Do not ent	er the mode of dying, such as card	iac or respiratory arre	est,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)  BREAST CANO Due to (or as a conse					
	Examiner			quence on.				
	p ti	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	quence of):				
	ecute and -trans	xam	Cause (Disease or injury that initiated events resulting in death) Last  C  Due to (or as a conse	quence of):		***		
68760,	ficate be executed physician and s the burial-transit	edical Examiner		quonios siyi				
	tificate ng phy as the		V					
Вох	death certificate be executed e attending physician and d for use as the burial-transit	an/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome pf preg	tal death 3 [	Ectopic pregnancy		23d. Date of deli	very Day Year
P.O. I	0 0	Physician/M	1 ☐ Yes 2 M No 9 ☐ Unknown 4 ☐ Pregnant at time of 9 ☐ Unknown	death 5	Other (specify)		Mona	Day Four
	iaw requires that the as been signed by the 2 should be detache	by Pr	Part II. Other significant conditions contributing to death but not re	sulting in the u	nderlying cause given in Part I.	23e. Did tob	acco use contribute to	the cause of death?
ord	w require been sig should b				<del></del>	_ 1 □ Ye	s 2 No 3 Pro	bably 4X Unknown
Records,	e law r has be	Completed				24a. Was ar autops	24b. Were au	topsy findings available ompletion of cause of
al F	n: The licate har, page	Co					X No 1 L Yes	2 □ No
or Vital	Physician: r this certific ral director,	o Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 [	☐ ER/Outpatier	Othori	eath (Check only one	nce 6 <b>X</b> Other ( <i>Sp</i> ec	HOCDICE
יסר	ding Physician: The land.  After this certificate has funeral director, page 2	n: To	27. Manner of Death 28a. Date of Injury	28b. Time o		28d. Describe ho		HUSFICE
Sior	Attending r death. ector: Afte	catio	2 Accident investigation		M 1 ☐ Yes 2 ☐ No			
Division	i gite	Certification:	4 ☐ Homicide determined 28e. Place of injury - At building, etc. (Spec		eet, factory, office	28f. Location (Str City or Town	reet and Number or Ru , State)	ral Route Number,
_	ospital hours a ineral y filled	a C	29a. Certifier 1X Certifying Physician: To the best of my kr					
	the Hospital hin 24 hours a the Funeral npletely filled	Medical	(Check only one)  2 Medical Examiner: On the basis of examinand manner stated.	nation and/or in				
	To with	2	29b. Signature and title of certifier		29c. License number D 4 3 7 2	1	9d. Date signed (Month	n, Day, Year)
	6		30. Name and address of person who completed cause of death (Its	m 23a) /Type		7	10/8/0/	
	10		DR. TARIQ MAHMOOD 2300 DULANE			, MD 21093	<b>,</b>	
	Sta		31. Date filed (Month, Day, Year) 32. Registrar's Sign	nature				
	Registr	ar	OCT 0 9 2007	K A	rester			

DHMH 17 Rev 1/2001

OCIOBER 6, 2007 3:35 p.m.

CAROLLE JACAPRARO

ORIGINAL

7-07708 acqueline Koet	he	Please Type or Print in Black Inc State of Maryland / Depar						
acqueime roet			tificate of		iu Meritai	r rygrerie Reg	. No. 20	07 3221
Physicia ledical Exami	an/	1. Decedent's Name (First, Middle,Last)  Jacquline Lee Koethe				2. Date of Death Month October 2, 2		3. Time of Death 1914 hrs
		4a. Facility Name (if not institution, give street and number) St Agnes Hospital	4	b. City, Town, o	r Location of De		4c. County of Dea	th /A
Funeral Director	1	5. Social Security Number unk 6. Sex 7. Age (In yrs. tas		If Under 1 Ye Months Da		Ain.	(MM/DD/YYYY) 9. E Fore	ign
		1 M   ✓ F 41  Usual Residence of Decedent	Yrs.	<u></u>		Feb. 8	, 1966	ountry) MD
tand f show any once,	tor	MD N/A	Town or Locati	Baltin	ore	Loc		10d. Inside City Limits 1 X Yes 2 No
the Mary a or 28a tiffed at	Director	10e. Street and Number 1701 Spence Street		10f. Zip Code	1230	log	u. Citizen of What Co United	
17215-0036  July be filed within 72 hours after death with the Maryland Mental Hygiene marked other than "natural", or items 23a or 28a-f show to event, the Medical Examiner must be notified at once.	Funeral	11. Marital Status  1 Never Married 2 Married Armed Forces?  1 Yes 2 No	5. 13. Was	s Decedent of H es, specify Cuba	ispanic Origin? in, Mexican, Pue	( Specify Yes or No- erto Rican, etc.)	White, etc.	erican Indian, Black,
urs after tural", aminer	ğ	3 Widowed 4 Divorced If Yas, Give Year or Dates:  15. Decedent's Education (Specify only highest grade completed)	16a. Deceden	Yes 2 X N t's Usual Occup	ation (Give kind		Specify: W 16b. Kind of Busines	hite s/Industry
36 in 72 hoi nan "na lical Exa	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	•	ost of working lif Packer	e. DO NOT use	retired)	Wareho	NISA
5-00; lted with Hygiene. I other th		17. Father's Name (First, Middle, Last) Charles Summers Koethe		GORCE		ame (First, Middle, Ma	aiden Surname)	
2121 uld be fi Mental marked c event,	To Be	19a. Informant's Name/Relationship (Type, Print )	19b. Mailing	Address (Stre	L	tina Franc		
MD nd 2 sho alth and m 27 is		Christina F. Koethe  20a. Method of Disposition 20b. Pl		Spence ition (Name of c		Baltimore,	MD 21230 20c. Location - City	
nore, ages 1 a mt of He nt: If ite	L,	1 Burial 2 X Cremation 3 Removal from State	rematory of oth	ndel		.0-9-2007	Odenton,	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", injury or other traumatic event, the Medical Examiner.		4 Donation 5 Other Specify: 21. g ur f Funeral Service Licensee	22. N	atory lame an Addre	ss of FacilityAm	brose Fune v Rd., Lar	eral Home,	Inc.
executed an and and transit	ical Examiner	or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of)  Due to (or as a consequence of)  Due to (or as a consequence of)  Due to (or as a consequence of)	·):					
o, e be exe y sician burial -		IF FEMALE:    X AMENDED #5, perFH, 23a, 27	7,28a-f,	perME,g87	<sup>7</sup> 2, 10/16/	/07 TT	23d. Date of deliv	90/
Box 68760, e death certificate be et the attending physicia ed for use as the buria	sician/Med	23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown  1 Unknown	2 Fe	tal death 3 her (Specify)	Ectopic pre	egnancy	Month	Day Year
P.O. Bees that the designed by the	by Physi	Part II. Other significant conditions contributing to death but not re-	esulting in the u	underlying cause	given in Part I.			to the cause of death?
cords, law requir has been s	Completed					24a. Was an autops perform	y prior t ned? death	
Vital Rec ysician: The his certificate director, page	ι συ	25. Was case referred to medical examiner?		26.Pla	ce of Death (Ch			103 2 110
of Vit Physic er this c eral dire	To B	1 🗸 Yes 2 No	ER/Outpatient 28b. Time of I		Other Nu		Residence 6 Ot	ner:
ion of tending Pl eath. tor: After the funera	ation	1 Natural 5 Ponding (Month, Day, Year)	unk	1	Yes 2X No	unk		
Division of ' spital or Attending Ph tours after death. teral Director: After t	Certification:	3 Suicide 6 X Could not be 4 Homicide 28e. Place of Injury - At ho		et, factory, office	building, etc.		treet and Number or ate) Ce St. Balti	Rural Route Number, City
To the Hospital within 24 hours To the Funeral completely filled	Medical Co	29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination an	ge, death occur	rred at the time, tion, in my opinio	date and place, on, death occurr	and due to the cause	(s) and manner as s	tated.
To wit To	Mec	and manner stated.  29b. Signature and title of certifier		29c. Licer	nse number		29d. Date signed (	Month, Day, Year)
į į		30. Name and address of person who completed cause of death (Item.	23a)	0.0	.M.E.		October 3, 200	11
//	1 1	Ana Rubio MD. Assistant Medical Examiner	111 Penn S	Street, Baltin	nore, MD 21	201		
S Regis	tate trar		re Asset	V				
			-		·			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item 5 per file 872 10-12-07 yt.

State of Maryland Department of Health and Mental Hygiene

amend item 1 per plocase 72 19-19-07 vt.

Reg. No. 200 Reg. No. 2007 1 - For State Registrar 32203 Date of Death
 Month 1. Decedent's Name (First, Middle, Last) Shirley Hayward Klaus 2007 Dav 2315 **Physician** BOOMFAF Oct. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Air Harford Count hesaneake Be pper If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 212-28-4228 7. Age (In yrs. last birthday) **Funeral** Months 1 M 2 F Director Martland Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show nit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla rartment of Health and Mential Hygiene.
ortant: If item 27 is marked other than "natural", or items 23a or 28a-1 shov injury or other traumatic event, the Medical Examiner must be notified at Pylesville 1 ☐ Yes 2 No Director Mariland Harterd Count 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Jenkins 21132 Kond 4307 States United Funeral 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 K No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: white Completed by 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Own Hard Home Maker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Street Catherine Arthur Brown ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any injury or other trau Pylesville, Mariland Road 4307 Jenkins 7113d Klavs Mr. William 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 【ACremation 3 ☐ Removal from State PC+- 11, 2007 Frest Hill, Maryland Evans Fineral Chapel 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility of from tim Services - Bel A. 21. Signature of Funeral Service Licensee Drine Nevnoit Friet HII, MD. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a conse tience of): **Physician** /Medical Examiner one. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a o insequence of) Examiner as the burial-transit ongestive and Due to (or as a consequence of) attending physician 10455 high mecords, P.O. Box 68/61 Physician/Medical IF FEMALE: for use If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) detached 9 Unknown 9 Unknown After this certificate has been signed by inneral director, page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 32No 1 Tyes 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes No 24a. Was an autopsy performed 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Inpatient 1 Tes 2 ER/Outpatient 3 DOA Certification: To Date of Injury (Month, Day Year) 27. Manner of Death 28a 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident I or Attend after death Director: the To the Hospital or Atter within 24 hours after des To the Funeral Director completely filled in by th 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide rtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 060768 5 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) upper Chesapeake Dr. , Belair, MD 21014 Jokhadar, 500 Muhammad 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Been Registrar 0 9 2007 DHMH 17 Rev 1/2001

ORIGINAL

			_ State of Maryland	d / Department of Health and Mental Hygier	ne .
		-	For State Registrar		2007 32204
	Physicia		1. Decedent's Name (First, Middle, Last)	2. Date of Death Month	Day Year 3. Time of Death
	/Medic	al -	Winifred Toole KINN	4b. City, Town, or Location of Death	5 200 7 330 H M 4c. County of Death
	Examin	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location or Death	Baltimore
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. I	ast birthday) If Under 1 Year   Wunder 24 Hrs.   8. Date of Birth   Months   Days   Hours   Min.   Month, Day, Yea	
	Director		217-38-5622 10M 20F 9	3 Yrs. Months Days Hours Min. 9-2-/	914 (1)
	and and	-	Usual Residence of Decedent  10a. State 10b. County 10c. City	/, Town or Location	10d. Inside City Limits
	Mary Indi	tor	MD Balhmore Co	akensville	1 ☐ Yes 2 ☐ No
	th the	Director	10e. Street and Number	10f. Zip Code 10g.	Citizen of What Country?
	ath w		13801 Vork Road	21030	14. Race - American Indian,
	ter de Items	Funerai	11. Marital Status   12. Was Decedent Ever in U. Armed Forces?   1 ☐ Never Married   2 ☐ Married   1 ☐ Yes   2 ☐ Mor	S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	Black, White, etc.
036	filed within 72 hours after death with the Maryland Hygione. ther than "natural", or Items 23e or 28e-f ahow ant. Ite Musical Examiner must be notified at	by	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:	1 ☐ Yes 2 ☑ No Specify:	Specify: White
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12	within ene. than	mp	Elementary/Secondary (0-12) College (1-4or 5+)	Educator A	F. duna havi
	a filed I Hygi other	Be Co	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maid	den Sumame)
Maryland	should be nd Mental marked o	To B	William Albaugh Toole	2,11,an B	Ollinger
lan	2 sho and I Is mu		19a formant's Name/Relationship (T , Print) Personal	19b. Mailing Address (Street and Number or Rural Route Number, Cit	ry or Town, <del>Sl</del> ate, Zip Code)
	1 and Health tem 27 other tr	3	20a. Method of Disposition 20b. P	Place of Disposition (Name of Date Oc	Location - City or Town, State
ltimore,	S +		1 □ Burial 2 ☑ Cremation 3 □ Removal from State  1 □ Donation 5 □ Other (Specify)	emetery, crematory or other place)	Elhoure MA
Baltii	permit. Pages 1 and Department of Health Important: If item 27 any injury or other ti once.	Ì	21. Signature of Funeral Service Licensee	22. Name and Address of Facility Product - A	Hor Fiveral Home
<u>~</u>	Depa Impo any ii		THE LAND	PH, 2134 Willow Sprike X	d 21222
			shock, or heart failure. List only one cause on each line.	h. Do not enter the mode of dying, such as cardiac of respiratory arrest,	Approximate Intervat Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	rape Duan a	1999-2007
	Examiner		Due to (or as a consequence to a consequ	uence or):	
	n\ . /=	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	uence of):	
	and A	Examiner	Cause (Disease or injury that initiated events c	tience of).	
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89	tificate g phys as the		d		
Вох	death certifical e attending phy d for use as th	an/N	IF FEMALE: 23b. Was deceden pregnant 1 ☐ Live birth 2 ☐ Feta		23d. Date of delivery  Month Day Year
о. П	0 0 0	ysici	in the past 12 months?  1 Yes 2 No 9 Unknown 9 Unknown	eath 5 Other (specify)	
۵.	The law requires that the death ate has been signed by the atte bage 2 should be detached for	by Physician/Med	Part II. Other significant conditions contributing to death but not res	ulting in the underlying cause given in Part I. 23e. Did tobac	co use contribute to the cause of death?
rds,	w requires been sign should be			1 ☐ Yes	2 No 3 Probably 4 Unknown
Record	e law re has bee	Completed		24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
		Con		performer 1 □ Yes 2 <b>X</b>	
Vital	Physician: The this certificate ral director, pag	Be c	25. Was case referred to medical examiner?  1 Yes 20 No Hospital: 1 Inpatient 2	26. Place of Death (Check only one)  ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence	a 6 □Other (Specify)
o		n: To	27. Mayner of Death 28a. Date of Injury	28b. Time of linjury Work? 28d. Describe how in Work?	
ion	Attending I r death. ector: After by the funer	atlo	2 Accident investigation	M 1 ☐ Yes 2 ☐ No	
Division	or Att	ertification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At he building, etc. (Specif.		t and Number or Rural Route Number, tate)
	Hospital or Attenc 24 hours after death Funeral Director: stely filled in by the	O	29a. Certifier 19 Certifying Physician: To the best of my kno	bwledge, death occurred at the time, date and place, and due to the caus	e(s) and manner as stated.
	To the Hospital or Attantwithin 24 hours after deall To the Funeral Director: completely filled in by the	edical	one) and manner stated.	ttion and/or investigation, in my opinion, death occurred at the time, date	
	To the within 2 To the complet	Σ	29b. Signature and Little of certifier	29d. License number 29d.	Date signed (Month, Day, Year)
•	17		36 Name and address of person who complete or cause of death (Item	m 23a) (Type, Print)	9//
	10		F. SANZAROND, 13	n 23a) (Type, Print) SOI YOLK RO, C'à Chapra	ele Mel 21030
*<	Sta		31. Date filed (Month, Day, Year) 32. Segistrar's Signal	ature	
	Regist	rair	OCT 0 9 2007 Broken	J. Grand	

DHMH 17 Rev 1/2001

October 5,2007 3,50AM

Winifed B. Kinn

ORIGINAL

			Please	Type or Prir					-		egible.		
	State of Maryland / Department of Health and Mental Hygiene  1 - For State State Certificate of Death Reg. N 2 0 0 7 3 2								2220	15			
			State Registrar Certificate of Death  1. Decedent's Name (First, Middle, Last)  2. Date of Death  2. Date of Death						001	3. Time of Dea	ith .		
Physic	cian		Sherry Lyr		sley				Octobe	Day	2007		рм
/Med Exam			4a. Facility Name (If not institution, give		31 Cy					ounty of Death	0.00		
Exam	mei		1614 Wood Tree Co					napolis		Á	nne Aru	ınde1	
Funera	Funeral 5. Social Security Number 6. Sex 7. Ag				e (In yrs. last birthday) If Under 1 Year   If Under 24 H			8. Date of Birth 9. Birthplace (State or Fore (Month, Day, Year) Country)			reign		
Directo	Director 528-50-2329 1 M 2 M F 68 Yrs. 1				Indiano Bayo	Sept.	(Month, Day, Year) Sept. 18 1938		Utah				
and w		-	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location						1	0d. Inside City Li	mits		
Maryl f sho	Š	5	Maryland Anne A	cundel			An	napolis			İ	1 □ Yes 2√∑	] No
r 28a	i con	3	10e. Street and Number							10g. Citize	n of What Cour	ntry?	
If it is in a constant with the Maryland filed within 72 hours after death with the Maryland Hygiene.  Hygiene "han" natural", or items 23a or 28a-f show nnt, the Merikal Examiner must be notified at	Cineral Directo	<u> </u>	1614 Wood Tree Co	ourt West				21409			USA		
ems er mu	200		11. Marital Status	12. Was Decedent Armed Forces?		S. 13.	Was Decedent of H	lispanic Origin? (S an, Mexican, Puert	pecify Yes or N to Rican, etc.)	0- 14	I. Race - Americ Black, White,		
s afte	10.75		1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	If Yes, Give "	1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		1 □ Yes 2 ☑ No		Specify:		White		
tural al Ex			15. Decedent's E	1			edent's Usual Occup			16b. Kind	d of Business/In	dustry	
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d with giene ar than	Completed	5	10	College (1-401)	) 		Homema	ker			Househo	old	
al Hy d othe	9	ומ	17. Father's Name (First, Middle, Last							o, Maiden Surname)			
should be and Mental marked o	F	2	James Bel			T		Bessie		Hewitt			
VICI 12 sh h and 7 is m traum			19a. Informant's Name/Relationship (		۱ اد ما		ing Address (Street						
Tand 2: Health are em 27 is other trau		-	Douglas M. Kinsle 20a. Method of Disposition	ey (husba	20h. F	lace of Disp	Wood Tre	i	Date		TS, MD ation - City or To		
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Merical Examiner must be notified at			1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special				ematory or other pla	, 000	. 08 2007	Dol+i	mana A	lanuland	
permit. F Departme Importan any injur	اتِ	-	21. Signature of Funeral Service Lies		THE	2	ematory I 22. Name and Addre					Maryland ome, P.A	
and med	5		Hill d. Sa	Dy ()			3111 Mou	ntain Ro					•
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one dause on each line.  Approximate Interval Between								in		
Physician	n		Immediate Cause (Final disease or condition  A Pulmonaud Edema								Onset and Dea	ın	
/Medica Examine			resulting in death)  Due to (or as a consequence of):										
		Sequentially list conditions, if any leading to immediate  Due to (or as a consequence of):						ny					
uted J ansit			Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events										
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ertifica ing ph e as t	Man	Physician/Inedica	IF FEMALE:	00. 1/									
box attendir for use	100	lan	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown  23c. If yes, outcome pf pregnancy 1 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)					23	23d. Date of delivery  Month Day Year				
the de ched		Ì											
Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and rall director, page 2 should be detached for use as the burial-transit		Dy P	Part II. Other significant conditions	contributing to death b	ut not res	ulting in the	underlying cause giv	ven in Part I.	23e. Did	I tobacco use	e contribute to	the cause of deat	h?
w requires to been signer should be a			1 Yes					Yes 2	No 3□ Pro	bably 4 ⊋onk	nown		
law re	100	Completed							24a. Wa	s an opsy	24b. Were aut	opsy findings ava	ilable e of
The ate h	1	5							per 1□ Yes	formed?	death? 1 ☐ Yes	2 No	
VICAL ician: ' ector, p	å	o o	25. Was case referred to medical examiner?  1					/					
Phys rthis		<u> </u>											
STOIL trending leath. tor: After the fune						Injury	M 1						
Atter ar dea ector		HCa				cme, farm, s	treet, factory, office 28f. Locatic			ion (Street and Number or Rural Route Number, or Town, State)			
tal or rs afte	1	Certification:	Ony or rown, class,										
Hospi 24 hou Funel stely fill	3	Icai	29a. Certifier 1 Certifying P (Check only one) 2 Medical Exa	hysician: To the best miner: On the basis	of examina	owledge, dea ation and/or	ath occurred at the t investigation, in my	ime, date and plac opinion, death occ	e, and due to th curred at the tim	e, date and p	and manner as place, and due	stated. to the cause(s)	
## G # G E E E E E E E E E E E E E E E E										. Date signed (Month, Day, Year)			
1 9 7 ( ) ( M) D0062087							10	10-8-2007					
1.	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  ERIKA D. FELLER, 22 S. GREENE ST. BALT.								. ~				
Y			ERIKA	J. FEZ	LEX		225	GREE	NE	57.	BAC	T. N	11)
S Regis	State		31. Date filed (Month, Day, Year)  OCT 0 9 200	82. Regist	rars Signa	ature	AP 0					/	
nog it			- 0 0 LOO	Par Steat Sout	200	1000							

Registrar DHMH 17 Rev 1/2001

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decement's Name (First, Middle, Last) 2. Date of Death **Physician** KURSCH. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death **Examiner** 2002 Flour Mill Court Crownsville Anne Arundel If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, JAN 12 5. Social Security Number 7. Age (In yrs. last birthday Birthplace (State or Foreign Country) **Funeral** 1**X**M 2□ F 1928 Maryland 218-22-8788 79 **Director** Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notifled at 1 □ Yes 2 No Director FLPasco 0dessa 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 33556 7214 Cypress Lake Drive USA Funeral Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 X Yes 2 No If Yes, Give Year or Dates: WWII 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify þ Specify: White 3 Widowed 4 □ Divorced "natural", Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 9 Longshoreman Foreman Shipping 7 Is marked other traumatic event, t 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Kursch George Agnes မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Item 27 I Paul Kursch - son 2002 Flour Mill Court, Crownsville, MD 21032 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If Ite any Inlury or oth 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) Metro Crematory, Inc. 10/5/2007 Baltimore, MD 21. Signature of Funeral Service Hersee H. Williams Cremation Society of Maryland, Inc. Vale 299 Frederick Road, Baltimore, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dving, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician /Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dun to (or as a consequence of) Examine The law requires that the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, ng physician as the burial Physician/Medical attending for use as IF FEMALE: use 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1☐Live birth 3 ☐ Ectopic pregnancy in the past 12 months? Day Year 4☐Pregnant at time of death 5 Other (specify) 2 No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy or Attending Physician: funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 ANO Other: 4 Nursing Home 5 Residence 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA 6 Sther (Specify) this Medical Certification: To 27. Manner of Death 1 Natural 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation (Month, Day Year) Injury М 1 ☐ Yes 2 ☐ No 2 ☐ Accident within 24 hours after death To the Funeral Director: completely filled in by the 1 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital Secrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

31. Date filed (Month, Day, Year)
OCT 0 9 2007

22. Registrar's Signature

Name and address of person who completed cause of death (Item 23a) (Type, Print)

21401

			State of Maryland / Department of Health and Mental Hygiene						
		•	1- For State Registrar Certificate of Death Reg. No 2007 32207						
	Physicia	an	1. Decedent's Name (First, Middle, Last)  2. Date of Death Month Day Year  3. Time of Death						
H	/Medic	al	Edwin Henry Knapp 10 4 2007 5:04 A M  4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death						
	Examin	er	Taching Name (n not monator), give successful namely						
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year   If Under 24 Hrs. 8. Date of Birth (Month Day Year) 9. Birthplace (State or Foreign						
п	Director		043-24-3750 76 Yrs. 09/06/1931 CT						
	and w		Usual Residence of Decedent  10a. State						
	Mary I-f sho fied a	ţċ	MD Anne Arundel Millersville						
	th the or 28c e noti	Funeral Director	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?						
	ath wis 23a	ral	8251 Ahearn Road 21108 U.S.A.  12 Was Decedent Ever in U.S. 13 Was Decedent of Hispanic Origin? (Specify Yes or No-						
	ter de items iner n	Fune	Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  Black, White, etc.						
21215-0036	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show tht, the Medical Examiner must be notified at	by	If Yes, Give 1 □ Yes 2 ☑ No Specify: Specify: White						
5-0	72 hc 'natul dical	Completed by	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired)						
121	within ene. than he Me	dmo	Elementary/Secondary (0-12) College (1-4or 5+)  1 Printer U.S. Government						
	should be filed within 72 hours after death with the Marylar ad Mental Hygiene. marked other than "natural", or items 23a or 228a-f show marked other than "natural", or items 23a or 228a-f show marke event, the Medical Examiner must be notified at	BeCc	17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Maiden Surname)						
/lar	uld be Menta arked artc ev	To B	Henry Knapp Freida Schmidt						
Maryland	12 should be f n and Mental F Is marked of raumatic ever		19a. Informant's Name/Relationship (Type. Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)						
	l and lealtl im 27		Mrs. Mody B. Knapp / wife 8251 Ahearn Road, Millersville, Maryland 21108  20a. Method of Disposition (Name of cemetery, crematory or other place)  Date 20c. Location - City or Town, State						
Baltimore,	<b>e = :</b>		1 Burial 2 MCremation 3 Removal from State 4 Donation 5 Other (Specify)    Removal from State   Crematory or other place)   Chesapeake Cremation   10/09/2007   Stevensville, MD						
altir	permit. Page Departmen Important; any injury once.		21. Signature of Funeral Service Licensee 22. Name and Address of Facility						
Ä	Depar Impor any ir		Singleton Funeral & Cremation Services 1 2nd Ave, SW Glen Burnie, Maryland 21061						
	Physician /Medical Examiner pnuisician and pnuisi-transit pnuisician and pnuisici	Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):						
P.O. Box 68760,	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Live birth 2   Fetal death 3   Ectopic pregnancy   23d. Date of delivery   1   Live birth 2   Fetal death 3   Ectopic pregnancy   Month Day Year   4   Pregnant at time of death 9   Unknown   Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?						
	ires th signec	þ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death?  1   Yes 2   No 3   Probably 4   Unknown						
Sore	w requir been si should	eted	24a. Was an 24b. Were autopsy findings available						
al Records,	sician: The law certificate has b irector, page 2 s	Completed	autopsy prior to completion of cause of death?  1 □ Yes 2 No 1 □ Yes 2 □ No						
·Vital	Physician: r this certifica ral director, p	To Be	25. Was case referred to medical examiner?  1   Yes						
on or	To the Hospital or Attending Physician: The Within 24 hours after death.  To the Funeral Director: After this certificate his completely filled in by the funeral director, page		27. Magner of Death    28a. Date of Injury   28b. Time of Injury   28c. Injury at Work?   28c. Accident   28d. Describe how injury occurred   28d. Describe how injury occurre						
Division		Certification:	3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)						
	he Hospit in 24 hour he Funer: pletely fille	edical	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.						
	To t with	M	29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Sear)  29b. Signature and title of certifier  29c. License number  29c. License number  29d. Date signed (Month, Day, Sear)						
	3		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 305 this pital Drug						
6	Sta	ate	31. Date filed (Month, Day, Year) 32 Registrar's Signature						
	Regist	rar	OCT 0 9 2007 Shew I have						

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician JOHN EDWARD KLASS, JR. OCTOBER 6:40 P.M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner STELLA MARIS HOSPICE TIMONIUM BALTIMORE If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 XM 2 □ F 212-26-6651 Director 78 3/27/1929 MARYLAND Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Director BALTIMORE PHOENIX 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 14004 SUNNYBROOK ROAD 21131 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any Injury or other traumatic event. the Madical Evantion 1 TYes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 ☐ No <u></u> Specify: WHITE 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) BALTIMORE COUNTY Elementary/Secondary (0-12) College (1-4or 5+) YEARS DRAFTSMAN 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be JOHN E. KLASS, SR. KATHERINE HOEFLER 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) DOLORES M. KLASS/WIFE 14004 SUNNYBROOK ROAD PHOENIX, \_MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Buriai 2 【\*\*Cremation 3 ☐ Removal from State METRO CREMATORY, INC. 10/9/2007 CATONSVILLE, MD 4 Donation 5 Dother (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses THE JOHNSON FUNERAL HOME, P.A. 8521 LOCH RAVEN BLVD. TOWSON, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one eause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** DEMENTIA /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine attending physician and Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ▼ Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No certificate has 2**X** No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 NOther (Specify) HOSPICE Hospital: Certification: To 1 ☐ Yes 2 👿 No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, 24 hours after death Funeral Director: Hospital

with the Maryland

death

To the within 2

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TARIQ MAHMOOD 31. Date filed (Month, Day, Year)

OCT 0 9 200

29b. Signature and title of certifie

29a. Certifier

(Check only one)

Medical

2300 DULANEY VALLEY RD. . Registrar's Signature

and manner stated,

29d. Date signed (Month, Day, Year)

TIMONIUM, MD 21093

Registrar

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

OCT 0 9 2007

MD

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) **Physician** Month Luther 2112pm Kichard October 05 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** The Johns Hopkins Hospital Baltimore City If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Yea July 31, 1 9. Birthplace (State or Foreign **Funeral** Days Hours 1 X M 2 □ F 1943 New York 089-36-5416 Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notifled at 1 ☐ Yes 2X No Director Norridgewock Maine Somerset 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 41 Pleasant Hill Drive 04957 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 1 Never Married 2 Married White 3altimore, Maryland 21215-0036 1 ☐ Yes 2 🔁 No þ Specify Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Heavy Equipment Operator State of Maine d 2 should be filed who and Mental Hygie. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic evone. Myrtle Widrig Eugene Luther 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bette Luther - Wife 41 Pleasant Hill Drive; Norridgewock, Maine 04957 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Sunset View Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 10-13-2007 Norridgewock, Maine 22 Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 21. Signature of Funeral Service License 1630 Edmondson Avenue; Catonsville 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ventricular Septal Rupture **Physician** 2 Hours disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Bacterial Endocarditis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine the burial-transi attending physician and resulting in death) Last Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4⊡Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. β 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

127 Yes 2 □ No 24a. Was an 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA ٩ 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending Injury 1 ∏Yes 2 ∏No investigation 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide

Division or Vital Records, P.O. Box 68760 within 24 hours at To the Funeral D

Lowe Elon, Medical Doctor State

(Check only one)

29b. Signature and title of certifier

29c. License number RES-000

29d. Date signed (Month, Day, Year) October 06, 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Larrel Brown The Johns Hopkins Hospital, 600 North-Wolfe Street, Baltiture Maryland 21287 32. Registrar's Signature Soules

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** LOGUE ALMA OE TOBER 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner JOHNS HORKINS BAYVIEW MEDICAL BALTIMORE CENTER BALTIMORE CITY If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) New York 5. Social Security Number Age (In yrs. last birthday) **Funeral** 1 □ M 2 1 F 90 13,1916 **Director** 108-12-0125 Dec. Usual Residence of Decedent 10a. State 10c. City, Town or Location show 10b. County r 28a-f show notified at 10d. Inside City Limits Director 1 ☐ Yes 2 No Baltimore Dundalk Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a or event, the Medical Examiner must be 21222 United States death v 8110 Murray Point Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Bace - American Indian 11. Marital Status Black, White, etc. 72 hours after 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 9 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify þ Specify. 3XXWidowed 4 □ Divorced White 'natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) filed within Elementary/Secondary (0-12) College (1-4or 5+) 1 and 2 should be filed w Health and Mental Hygier IM 27 is marked other th 12 Years Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Department of Health and Menta Important: if Item 27 is marked any injury or other traumatic evonce. Mary S. Harrington Raymond E. Garfield ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8111 Longpoint Road Dundalk, Maryland 21222 (Daugnter) Kathleen Heins 20b. Place of Disposition (Name of cemetery, crematory or other place) Pages 1 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Zawn Cemetery 10/9/2007 Baltimore, Maryland 4∏Donation √5 ☐ Other (Specify) 21. Signature 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222 23a. Partt. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** CEREBRAL HERNIATION disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner 24 HOURS STROKE Sequentially list conditions, Examiner Disa to for ea a consecuence of cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Physician/Medical as 1 attending p for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 ☐ Ectopic pregnancy Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown à signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tes 2 No 3 ☐ Probabiy 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No page 2 has autopsy performe Yes 2 certificate Yes Physician: 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1 Inpatient P 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Certification: Hospital or Attending 5 ☐ Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: filled in by the 6 Could not be determined 3 ☐ Sulcide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Medical Decrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MD. RES-000 OCTOBER 6, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

OCT 0 9 2007

P.O. Box 68760,

Division or Vital Records,

32. Registrar's Signature

ELIZABETH HARRIS, BAYVIEW MEDICAL CENTER, 4940 EASTERN AVENUE, BALTIMORE, MARYLAND 21224

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Geraldine Marie Lemmer Oct /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gilchrist Hospice Towson Baltimore If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth
(Month, Day, Year)
Sept. 14,1919 5. Social Security Number 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) **Funeral** Months 1 □ M 2 🔽 F 112-09-7588 88 **Director** PA Usual Residence of Decedent Pages 1 and 2 should be filed within 72 moust and 2 should be filed within 72 moust after the file and Mental Hygiene.
Innert of Health and Mental Hygiene.
It is marked other than "natural", or items 23a or 28a-f show tant: if the 27 is marked other than "natural", or items 23a or 28a-f show that: if the 27 is marked other than "natural", or items 23a or 28a-f show that it is marked other than "natural", or items 23a or 28a-f show that it is not a should be 10c. City, Town or Location 10b, County 10d. Inside City Limits Director 1 ☐Yes 2 ☐ No MD Baltimore Kingsville 10e, Street and Number 10g. Citizen of What Country? 10f. Zip Code 11606 Chapman Rd 21087 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify þ Specify: 3 → Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Wilder Beckwith ပ္ Marian Ford 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Mary Glynn-Daughter mportant: If Item 27 any injury or other tr 11606 Chapman Rd Kingsville, MD 21087 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gardens of Faith 10/10/07 Baltimore, MD 21. Signature of Funeral Service Licersee 22. Name and Address of Facility Sterling-Ashton-Schwab-Witzke Funeral Home UI Catonsville, IIIC.
1630 Edmondson Ave Catonsville, MD
Approximate Interval Between One cause on each line.

21228
Approximate Interval Between Onesi and Death Funeral Home Of Catonsville, M 23a. Part1. Enter the disea e shock, or heart failure. Immediate Cause (Fin Physician ONTHS disease or condition resulting in death) /Medical Due to (or as I nsequence of) Examiner Sequentially list conditions, if my, backing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a nonsequence of: requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Day 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 robably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy this certificate or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2000 1 ☐ Yes To the Hospital or Attending Priys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir 2 ER/Outpatient 3 DOA 1 Inpatient Medical Certification: To 27. Manner of leath

| Datural
| Accident 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier

Registrar

State

Baltimore, Maryland 21215-0036

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Records,

Division or Vital

DHMH 17 Rev 1/2001

**ORIGINAL** 

D64395

N CHAPLES ST, SUITE 209 BALTIMORE, MD 21204

OCTOBER 8, 2007

and manner stated.

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32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DANIEUE DOBERMAN, MA

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 2007 a /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Months Min Director :10-1954 Usual Residence of Deceden Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location works i 10b. County 10d. Inside City Limits ns 23a or 28a-f show must be notified at 1 **K**es 2 □ No **Funeral Director** timare Street and Number 10g. Citizen of What Country? items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Armed Forces?
1 ☐ Yes 2 No
If Yes, Give
Year or Dates: Black, White, etc. Examiner 1 ☐ Never Married 🌠 Married ò Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. þ 3 Widowed 4 Divorced "natural" Be Completed Health and Mental Hygiene. Iem 27 Is marked other than "natur other traumatic event, the Medical. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Jea rmon Informant's Name/Relationship (Type. Print, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Important: If item 27 any Injury or other tr 5 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify) 3 ☐Removal from State 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dy shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** V D 64 /Medical Due to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner or Attending Physician; The law requires that the death certificate be executed physician and s the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by disord 1 Tyes 2 No 3 Probably 4 Unknown page 2 should 24a. Was an Were autopsy findings available prior to completion of cause of performed? Yes 212 No death? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? funeral director 26. Place of Death Check onl one Other: 1 ☐ Yes 2 ☐ No Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 2 ☐ Accident Injury 1 ☐ Yes 2 □ No within 24 hours after death.

To the Funeral Director: A 6 ☐ Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide the Hospital Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0 D0057563 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year)

OCT 0 9 2007

DHMH 17 Rev 1/2001

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Naman

2. Registrar's Signature

Loch Laven Blud.

Baltimore

21239

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1- State Registrar 32214 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Oct.2, 8:56A M 2007 Juanita Alanita Mims /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Sinai Hospital Baltimore If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2√2 F Yrs **Director** 220-30-4447 Dec. 9. 1935 N.Carolina Usual Residence of Decedent r 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits XYes 2□No Director Maryland N/A Baltimore 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? o e Funeral 4107 Kathland Avenue 21207 USA ral", or items ? 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ★No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Black Specify Completed by 3 □Widowed 4 □ Divorced 'natural", 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry the Medical (Give kind of work done during most of working life. DO NOT use retired) Parke-Davis Elementary/Secondary (0-12) College (1-4or 5+) 11th grade Ouality Control Pharmaceuticals Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 should be finance of and Mental H Pages 1 and 2 should the nent of Health and Men Lucy Boone James Crossen 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21207 19a. Informant's Name/Relationship (Type. Print) S 4107 Kathland Avenue Baltimore, Maryland Gwendolyn Copeland/Daughter other t Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Woodlawn Cemetery 10/6/07 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State 4 Donation 5 XX her (Specify) Entombrent = 5 Woodlawn, Maryland Important: I any Injury o 21. Signature of Funeral Service Licensee, 22. Name and Address of Facility Chatman-Harris Funeral Home 5240 Reisterstown Rd Baltimore, Md 21215 23a. Part1 Inter the disase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, show, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Fin I disease or condition resulting in death) **Physician** immed walat /Medical Due to (or as a consequence of): actory desease Cheart attack Examiner Corman Sequentially list our ditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Examiner requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760; Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Day Month Year 4□Pregnant at time of death 5 ☐ Other (specify) 9∐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an page 2 s autopsy
performed2 1□ Yes 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No Certification: To 1 Inpatient 2 ER/Outpatient 3 □ D0A 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident after death Director; 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide 24 hours a e Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. within 2 29c. License number 29b. Signature and title of certified 29d. Date signed (Month, Day, Year) MO 30 Name and appress of person who completed cause of death (Item 23a) (Type, Print)

ARM HUMEL MID & 1269 N. Chau les St Balt Md 21204 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 0 9 2007

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Edna Eloise McLean 2007 4a. Facility Name (If not institution, give street and number 4b. City\_Town, or Location of Death 4c. County of Death N/A THION CITO If Under 1 Year Birthplace (State or Foreign Country) If Under 24 Hr 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number Days Hours Min Months 1□ M 3√√F 218-42-2224 20,1942 Virginia Nov. Usual Residence of Decedent 10c. City, Town or Location Baltimore 10d. Inside City Limits 10a. State 10b. County N/A Maryland 1√Yes 2□No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? USA 21215 3314 Sumter Avenue 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2☐ Married Black 1 ☐ Yes 2√2 No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Day Care Provider Self-Employed 12th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Louise Hill George Toliver 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21215 19a. Informant's Name/Relationship (Type. Print) 3314 Sumter Avenue Baltimore, Maryland / Husbaḥd Hubert McLean, Jr. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a, Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Arbutus Memorial Park Arbutus, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Chatman-Harris Funeral Home 21. Signature of Funeral Service Lic 👊 e a 5240 Reisterstown Rd Baltimore, Md 21215 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, snock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 30 MIA disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy

1 ☐ Live birth 2 ☐ Fetal death

4 ☐ Pregnant at time of death 23d. Date of delivery 3 Ectopic pregnancy Month Year 5 ☐ Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? death? 1 ☐ Yes 2□ No 1∐ Yes 2 No medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 FR/Outpatient 3 DOA

Physician /Medical Examiner

**Physician** 

/Medical

**Examiner** 

**Funeral** 

Director

28a-f show

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items 23a

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permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra

Baltimore, Maryland 21215-0036

and 2 should be

be notified Director

Examiner must

Funeral

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Completed

and burialthe as attending asn ō the detached þ signed peen has page 2 certificate this

Exami

Physician/Medical

þ

Completed

Be

2

Certification:

Medical

State

death certificate be executed

P.O. Box 68760

Records,

or Vital

Division Hospital or Attending 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown

ı	20.	examiner?		to medic				
ł								
ļ		1 👺 Yes	2□ No					
Ì	27	Manner of Dooth						

28a. Date of Injury (Month, Day Year) 5 ☐ Pending investigation

28h. Time of

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

29a. Certifier (Check only one)

1 👹 Natural

2 Accident

3 ☐ Suicide

4 ☐ Homicide

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29b. Signature and title of certifier

6 ☐ Could not be

determined

29d. Date signed (Month, Day, Year)

30. Name and address of person who cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year) OCT 0 9 2007 2. Registrar's Signature

within 24 hours after death. To the Funeral Director: After

To the

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completely

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year 4:22 PM McFarlan Frederick 10 Z007 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Baltmore Mary land Med Ctr University of If Under 1 Year If Under 24 Hrs. Months Days Hours Min. (Month, Day, Year) Oct. 18,1935 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number Birthplace (State or Foreign Country) Months 1 XM 2 F 225-40-0102 71 Virginia Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b, County 10d. Inside City Limits Virginia 1XYes 2 No Frederick Stephens City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5258 Germain Street 22655 U.S.A. 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🗷 No Specify: Specify: White 3 ☐ Widowed 4 ☑ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Truck Driver Shipping 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ernest Lee McFarland Mildred P. Stottlemyer 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frederick G. Mcfarland, Jr. / Son 184 Dicks Hollow Rd.Winchester, VA 22603 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition October 6 Macedonia (Inited Methodist Church Cem. 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 2007 Stephens City, VA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Enders & Shirley Funeral Home 21. Signature of Funeral Service Lansee P.O. Box 757, Stephens City, VA 22655 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Multi Organ System Due to (or as a consequence of): mantl Concer Dise to for as a consequence of Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Vear 5 ☐ Other (specify) 4□Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Mnknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an 1□ Yes 2☑No

**Physician** /Medical **Examiner** 

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Importants if Hean 23a or 28a-f show Importants if Hean 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at

1 and 2 should be filed within 72 hours after whealth and Mental Hygiene. Health and Mental Hygiene. In 27 is marked other than "natural", or iten

Maryland 21215-0036

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Sequentially list conditions, if any, leading to infried at cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 ( Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

(Check only

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c, License number

29b. Signature and title of certifier

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Bathmore,

29d. Date signed (Month, Day, Year) 2007

30, Name and address of person who completed cause of death (Item 23a) (Type, Print)

Greene trausta Wh 22 Street,

State Registrar

OCT 0 9 2007

31. Date filed (Month, Day, Year)



MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 2007 4:25 PM 06 Eleanor T. McDermott /Medical Eacility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HeALTHAND HAR FORD Kepph If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 10–16–1911 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 7. Age (In yrs. last birthday, **Funeral** Days Hours 1 □ M 2 🛛 F 95 **Director** 217-05-5812 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at show 1 ☐ Yes 2 No Director Harford Maryland Fallston 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? "natural", or items 23a or 1217 Peachtree Rd 21047 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White ò 3 X Widowed 4 ☐ Divorced Completed of Health and Mental Hygiene. item 27 is marked other than "natul other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 10 +Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Frank Novakowski Catherine (Unknown) ۵ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health of item 27 i William P. Strickland Jr. 1217 Peachtree Rd Fallston, MD 21047 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of Important: If it any injury or o once. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State St. Stanislaus Cem. 10-10-2007 Baltimore, Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Schimunek Funeral Home of Bel Air Inc. 610 W. MacPhail Rd Bel Air, MD 21014 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician ardiopul monar disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner 6 months holangio carcinomo Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a confequence of) Physician/Medical Examiner use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 month 1 Yes 2 No 3 Ectopic pregnancy Day 4□Pregnant at time of death 5 Other (specify) been signed by the should be detached 9□Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 100 3 Probably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an cate has page 2 s autopsy perforr certificate 1□ Yes or Attending Physician: funeral director. 25. Was case referred to medical examiner? Medical Certification: To Be 26. Place of Death (Check only one) Hospital: Other: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred After Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident completely filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined

after death. To the Hospital within 24 hours a

To the Funeral Registrar

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29a. Certifier (Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Benjamin

30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

Lee, MD

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32. Revistrar's Signature

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D0063981

29d. Date signed (Month, Day, Year)

10

Havre de Grace MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.2 Decedent's Name (First, Middle, Last) 2. Date of Death October 2, Physician 2007 Frances Marion Milnor 11:15 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 1511 Arbutus Avenue Halethorpe Baltimore 8. Date of Birth Mar. 12, 1913 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours 1 □ M 2 😿 F 212-09-3537 94 Maryland Director Usual Residence of Decedent permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event the Maryland. 10b. County 10c. City, Town or Location 10d. Inside City Limits Baltimore MD Halethorpe 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1511 Arbutus Avenue 21227 United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give X 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No White Baltimore, Maryland 21215-0036 Specify. \$ 3X Widowed 4 □ Divorced Year or Dates Completed 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Everett Brown Abbott Adele Marie Seltzer 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1511 Arbutus Ave., Halethorpe, MD 21227 19a. Informant's Name/Relationship (Type. Print) Linda P. Milnor - Daughter 20b. Place of Disposition (Name of Mean of Title of Or other place) 20c. Location - City or Town, State Method of Disposition

Y☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Date 10-5-2007 Elkridge, MD Donation 5 ☐ Other (Specify) Memorial Park 22. Name and Address of Facility Ambrose Funeral Home, Inc. 21. Signature of Eurreral Service 1328 Sulphur Spring Rd., Arbutus, MD 21227 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 05 YEARS /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the death certificate be executed burial-trar Due to (or as a consequence of): ed by the attending physician detached for use as the buria Physician/Medical use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 4□Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown cate has been signed by a page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Completed 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No autopsy performed? Yes 221No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 🐪 lo Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28h. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 ☐ Pending investigation 1 Yes 2 No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier

Division or Vital Records. P.O. Box 68760. To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, t

> State Registrar

31. Date filed (Month, Day, Year) OCT 0 9 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Benson Ave. Baltimore MD 2(227 32. Registrar's Signatu

Medical

29c. License number

D51018

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 11cm 26 per doc 2872 10-9-07 vt. State of Maryland / Department of Health and Mental Hygiene 2 0 0 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year September 28, 2007 **Physician** Margaret Τ. Madden 2:10 p /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMORE Co. 21101 Keenev Mill Rd. Freeland If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 M 2 M FEB Director 215-12-7732 10, Maryland Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location show "natural", or items 23a or 28a-f shov idical Examiner must be notified at 1 thes 2 □ No Director Md. === Baltimore City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 600 Light Street U.S.A. Apt. 725 21230 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specity Yes or No-if Yes, specity Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No 3altimore, Maryland 21215-0036 Specify: Completed by 3 Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry nd Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ( h and Mental F ပ John С. Haves Theresa Bowman 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If item 27 is any injury or other trauonce. Mary Treadwell, sister 21101 Keeney Mill Rd. Freeland, Md. 21053 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐Cremation 3 ☐Removal from State 4 □ Donati 5 Cher (Specify) Meadowridge Mem Park 10/1/2007 | Elkridge, Md. 22. Name and Address of Facility Gonce Funeral Service P.A. 21. Signatur Funeral Service Licensee 4001 Ritchie Hgwy. Baltimore, Md. 21225 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) tastatic Colon **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to in mediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for eare nonsequence of Physician/Medical Examiner burial-tra Due to (or as a consequence of): Records, P.O. Box 68760, the attending p for use as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown certificate has been signed I rector, page 2 should be det 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1□ Yes 2 No Division or Vital Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home Sidence 6 Nother (Specify) sister's 1 Yes 2 No Certification: To 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After t 1 Natural 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours at To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) and manner stated 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ST Gaul Place Foldw 9 2007 0

Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 2,2007 OCTOBER 07:28 a M **DEVON** JAMAL MASSIE /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death GREATER BALTIMORE MEDICAL CENTER TOWSON BALTIMORE If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 112 M 2 □ F Director 3 10/02/2007 MARYLAND Usual Residence of Decedent 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at MARYLAND BALTIMORE OWINGS MILLS Director 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9113 THISTLE DOWN ROAD #197 21117 USA Funeral Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married "natural", or Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify <u></u> 3 Widowed 4 Divorced UNKNOWN BLACK Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry within 72 Elementary/Secondary (0-12) College (1-4or 5+) permit, Pages 1 and 2 should be filled w Department of Health and Mental Hygien Important: If Item 27 is marked other thin any Injury or other trainmant N/AN/A 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be DAMON MASSIE SHEMIRRA HOUSE 19a Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) N. Charles ST 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c Location - City or Town, State 1 Burial 2 Cremation 3 ☐Removal from State CENMOUN OCT. 5, 2007 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses HUNRY W. JENKINS SONS ONACO 4 York 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** EXTREME FREMATURITY /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Error unority graves (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Physician: The law requires that the death certificate be executed burial-tra Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. physician Physician/Medical attending properties for use as IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown þ signed to be detailed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☑ No 24a. Was an page 2 s certificate has autopsy performed's 1∐ Yes 2 No 25. Was case referred to medical examiner? funeral director Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ို 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient this 27. Manner of Death Date of Injury 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending (Month, Day Year) 1 🔀 Natural 5 Pending investigation Injury Apital o.
4 hours after dea.
• ratal Director: A 2 Accident 1 ☐ Yes 2 🗌 No 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a Funeral [ \*\*Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier completely (Check only one) within 2 29b. Signature and title of sertifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) THELMA S. ASARE, M.D. 1205 York Road, #14, Lutherville MD 21093 31. Date filed (Month, Day, Year) egstrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2007 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Month 14:58 Mitchell Gerald E. 2007 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) University of Maryland Medical Center Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex Days Months 1 M 2 ▼F JULY 15, 37 248-21-3763 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location ¥ Yes 2 No BALTIMORE DUNDALK 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 7934 ST. MONICA\_DRIVE 21222 USA 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 📉 No Specify. Specify 3 Widowed 4 Divorced BLACK 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) TRUCK DRIVER DS PIPE SUPPLY CO. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) EDDIE MITCHELL **ELENORA SMALLS** 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) DUNDALK, MD LETICIA CLAIR/FIANCEE 7934 ST. MONICA DR. 21222 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition METRO CREMATORY 10-11-07 BALTIMORE, MD 22. Name and Address of Facility JAMES A. MORTON & SONS F.H., INC. 21. Agna Lire of Funeral Service Licensee 1701-31 LAURENS ST. BALTIMORE, MD 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Airway Obstruction Due to (or as a consequence of): Laryngeal Cancer 17 tage Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months?

**Physician** /Medical Examiner

permit. Page Department o Important: if any injury or <u>≒</u> 5

**Physician** 

/Medical

**Examiner** 

10a. State

MD

**Funeral Director** 

Completed by

Be

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**Funeral** 

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene.

nt: If Item 27 is marked other than "natural", or items 23a or 28a-f show

Baltimore, Maryland 21215-0036

of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at

physician and is the burial-trans attending p for use as as signed by the aid be detached for been si should I cate has t page 2 s certificate the Hospital or Attending Physician: this certific al director,

The law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760,

Examine Physician/Medical þ Be Completed Certification: To After this funeral c within 24 hours after co...
To the Funeral Director: Aft Medical

	1  Yes 2 No 9 Unknown	9□Unknown				
	Part II. Other significant conditions	contributing to death but not res	sulting in the underlying	cause given in Part I.	23e. Did tobacco	use contribute to the cause of death?  ☐ No 3 ☐ Probably 4 ☐ Unknow
					24a. Was an autopsy performed? 1  Yes 2  No	24b. Were autopsy findings available prior to completion of cause of death?  1 Yes 2 No
	25. Was case referred to medical examiner?			26. Place of D	eath Check only one	
ı	1 Yes 2 No	Hospital: 1 Inpatient 2	ER/Outpatient 3□ I	OOA Other: 4 ☐ Nursing	Home 5 ☐ Residence	6 ☐Other (Specify)
I	27. Mann f Death 1 Natural 5 □ Pending 2 □ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how inju	ry occurred
	3 Suicide 6 Could not be determined		ome, farm, street, factory)	ory, office	28f. Location (Street ar City or Town, State	nd Number or Rural Route Number, e)
		nysician: To the best of my kn miner: On the basis of examin				s) and manner as stated.  Indicates and due to the cause(s)

State Registrar

Lemkin 31. Date filed (Month, Day, Year) OCT 0 9

29b. Signature and title of certifier



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

St. Baltmore Greene

29c. License number

29d. Date signed (Month, Day, Year) 2007

21201

MD.

filed within 72 hours after death with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If Item 27 is marked other than "naturel", or Items 23s or 28e-f ehow any Injury or other treumatic event, the Madical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

P.O. Box 68760,

Division of Vital Records,

Physician /Medical **Examiner** 

The law requires that the death certificate be executed physician and the burial-transit as use detached signed by page 2 should be been this certificate or Attending Physician: funeral director. After within 24 hours after death. To the Funeral Director: A the completely filled in by To the Hospitel

1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month 10 11:33 **Physician** A M MCGEE JIMMY Louis 2007 04 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Bayview Baltimore Johns Hopkins If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex Hours Days Months 65 March 11, 1942 429-76-8531 Arkansas Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 □ No Director Maryland Baltimore Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA North Point Road 21219 7720 Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Ves 2 No
If Yes, Give Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: Whate 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Container) Manufacturing College (1-4or 5+) Elementary/Secondary (0-12) Lathe operator 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Henry McGee Louis Wilma Coker 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Baltimore, MD 21219 Marilyn Jo McGee 1720 North Point Road 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Harrier, MD Anatony Gifts Registry October 4,2007 4. Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Angtony Gifts Registry 21. Signature of Funeral Service Licensee 1 1522 Connelley Drive Suite P. Handver, MD 21076 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ACUTE MYOCARDIAL INFARCTION HRS Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 Other (specify) 9□ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ TYPE II DIABETES MELLITUS 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? HYPERLIPIDEMIA 24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 ☑ No 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifile D 0026575 10-06-07 30. Name and address of person to completed cause of death (Item 23a) (Type, Print) COCKEYSVILLE, MD 21030 10155 YORK RD STE 200 DAVID J. HARTIG, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar OCT 0 9 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** 9:05 A M ELEONORE OCTOBER 4, 2007 MABE /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FOREST HILL HEALTH & REHAB CENTER HARFORD FOREST HILL If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Date of Birth (Month, Day, Year) 4/10/1914 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign **Funeral** Days 1 M 2 T 93 212-16-3923 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 No Director MD Harford Forest Hill 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21050 109 Forest Valley Drive USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 XNo If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify 3 XWidowed 4 Divorced White Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) File Clerk Social Security 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be P <u>Lawrence Marcinial</u> <u>Sophia Pawlak</u> 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Deborah J. Harrison 822 Randolph Drive, Aberdeen. MD 21001 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 10/6/2007 Glen Haven Cemetery : Glen Burnie, MD 4 □ Donation 5 □ Other (Specify) rvic Ligens 21. Signature of Funera S 22. Name and Address of Facility Stallings Funeral Home, P.A. 3111 Mountain Rd., Pasadena, MD 21122 institute caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, use on each line. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complication shock, or heart failure. List only one complications are complicated as the complete shock of the complete Immediate Cause (Final **Physician** acute respu disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a surresquence of): Examiner the death certificate be executed burial-transit and Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the buria Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) signed by the a d be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? Yes 2 No certificate Attending Physician: To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No Hospital: 3□ DOA 1 🔲 Inpatient 2 ER/Outpatient Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3□ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 📉 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar DAVID DUNN

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

0 9 2007

615 W. MACPHAIL ROAD

32. Registrar's Signature

03229

21014

BEL AIR, MD.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month 2007 3:30 p <sup>M</sup> Gene W Meekins October 1 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 208 Montrose Avenue Baltimore Catonsville If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours 1**X**M 2□F Country) **MD** SEP 14 1926 216-20-8288 81 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a, State 10d. Inside City Limits items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 XNo Director Catonsville MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21228 1 and 2 should be filed within 72 hours after death v Health and Mental Hygiene. em 27 is marked other than "natural", or items 23a 208 Montrose Avenue USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ★ Yes 2 □ No If Yes, Give Year or Dates: WWII 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced White Completed Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Salesman **Furniture** permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If item 27 is marked other any Injury or other traumatic event, I 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Nicholas Smith Meekins ပ္ Louise **Ellwood** 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 208 Montrose Avenue, Catonsville, MD 21228 Angeline Meekins - wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metro Crematory, Inc. 10/5/2007 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD 21. Signature of Funeral Service Licensee H. Williams <sup>22</sup> Cremation Society of Maryland, Inc. 299 Frederick Road, Baltimore, MD 21228 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the shath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner the Hospital or Attending Physician; The law requires that the death certificate be executed Due to (or as a consequence of) Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ No Completed 1 ☐ Yes 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy 25. Was case referred to medical examiner? 1 Yes 2 No
27. Manner of Dear
12 Natural
2 Accid Be 26. Place of Death (Check only one) Other: 4 Nursing Home 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 5 Residence 6 □Other (Specify) this 28a. Date of Injury (Month, Day Year) 28b. Time of After t 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Injury within 24 hours aner .c...
To the Funeral Director: Aft 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

Division or Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

State Registrar

Medical

29a. Certifier

OCT 0 9 2007



🛣 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

State of Maryland / Department of Health and Mental Hygien ? 7 32225 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** 9:57 P.M John G. McKinley, III 7, 2007 October /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Dove Hospice House Westminster Carrol1 If Under 1 Year If Under 24 Hrs. Wonths Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** Months 1 🔀 M 2 🗆 F Director 187-20-8882 80 Pennsylvania Dec.13, 1926 Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a, State 10b. County 10c. City. Town or Location 28a-f show other traumatic avant, the Medical Examinational Land Legislified at 1 ☐ Yes 2🛣 No Directo Maryland Carroll Sykesville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or Itams 23a 70 Brass Eagle Court Funeral 21784 12. Was Decedent Ever in U.S. Armed Forces?

1 XYes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 β 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 Widowed 4 Divorced Year or Dates: WWII "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) filed within 7 Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 should be filed wi h and Mental Hygien 7 is markad othar th 5+ Deputy General Manager Westinghouse 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be John G. McKinley, Jr. Esther Louise Cunningham 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) s 1 and 2 s of Health an Mary Eleanor McKinley Wife 70 Brass Eagle Court; Sykesville, MD 21784 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Important: If Ita any injury or ot once. 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Metro Crematory 10/8/2007 Catonsville, Maryland ¹ 4 □ Donation 5 □ Other (Specify) 21. Signature of uneral Service Lice 22. Name and Address of FacilitSterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. Fart 1. Enter the disease, or complications that caused the death of the mode of dying, such as cardiac or respiratory arrest, solicity Course (Cardiac or respiratory arrest, solicity Course) (Cardiac or respiratory arrest, solicity Course) (Cardiac or respiratory arrest, solicity Course) (Cardiac or respiratory arrest, solicity Course) (Cardiac or respiratory arrest, solicity Course) (Cardiac or respiratory arrest, solicity Course) (Cardiac or respiratory arrest, solicity Course) (Cardiac or respiratory arrest, solicity Course) (Cardiac or respiratory arrest, solicity Course) (Cardiac or respiratory arrest, solicity Course) (Cardiac or respiratory arrest, solicity Course) (Cardiac or respiratory arrest) (Car Approximate Interval Between Onset and Death NOW SMALL CARCINOMA OF LUA9 Immediate Cause (Final 2 years Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine certificate be executed as the burial-transit the attending physician and resulting in death) Last Due to (or as a consequence of): Records, P.O. Box 68760 Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy be detached for in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown ed by Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 s perform 1 Yes 2 No Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) DOVE HOUS 2 1 🗌 Yes 1 Inpatient funeral dir 2 ER/Outpatient 3 DOA this 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: Injury at Work? al or Attanding P after death. I Director: After After 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation the 6 Could not be determined 3 🔲 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To tha Funaral C To tha Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Rmas K-Jalua CM III 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) THOMAS K. GALVNII MO AUCHUR WESTMINSTER 291 STONER 32 Registrar's Signature 31. Date filed (Month, Day, Year) OCT 0 9 2007 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 3 Physician MURRAY JOHN October 2607 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Black Baltimonia Baltmore (our Iars if Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday **Funeral** 1**X**M 2□ F 93/ Maryland Director 212-26-2839 09/28 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must he notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland **Baltimore** Catonsville 1 ☐ Yes 2 No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1301 Black Friars Road 21228 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 X Never Married 2 ☐ Married 1 Yes 2 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1948–54 1 ☐ Yes 2 ☑ No Specify Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Sales Lumber 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Francis Guy Murray Neva E. Myer ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Suzanne M. Hale Niece 4827 Norrisville Road; White Hall, Maryland 21161 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☑Cremation 3 ☐Removal from State Metro Crematory 10/5/07 Catonsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Juneral Service Licens 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue; Catonsville, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) DISCUSO Obstructus Palmonari **Physician** KYONIC 7 years /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence or). Examiner The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, the attending physician Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 Other (specify) been signed by should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? page 2 autopsy performe After this certificate 1☐ Yes 2 No 1 ☐ Yes 2 ☐ No Attending Physician: 25. Was case referred to medical examiner? funeral director. Be 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28b. Time of 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 1 Natural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident al or Attend efter death the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 🗺 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 2720

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 32227 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Oct 4,2007 12:55am M Takako N. Munn /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Charles Co LaPlata 9040 Bridgett Lane If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 ☐ M 2 🕏 F Yrs. Director 157-70-9530 Ja<u>pan</u> 4/14/1947 60 Usual Residence of Decedent the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a State 10h County item 27 is marked other than "natural", or Items 23a or 28a-1 show other traumatic event, the Madical Examinar must be notified at LaP1ata 1XXYes 2 □ No Md Charles Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9040 Bridgett La 20646 Japan death by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 2 should be filed within 72 hours after of and Mental Hygiene. 1 Never Married 2 Married Specify: Asian Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) 2yrs Elementary/Secondary (0-12) Domestic Housewife 17. Father's Name (First, Middle, Last)
Zenshiro Naya 18. Mother's Name (First, Middle, Maiden Sumame)
Toshiko Naya Be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 te m any injury or other traum <u>pnce</u>. 9040 Bridgett Lane LaPlata Md 20646 James Munn Jr 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Lee Crematory or o 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State Clinton Md Oct 5, 2007 5 Other (Specify) 4 Donation 22. Name and Address of Facility Lee Funeral Home 6633 Old Alexandria Ferry Rd Clinton Md 20735 21. Signatura Juneral Service 963 Enjer the divease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease of condition resulting in death) ESOPHAGEAL METASTATIC Physician YEARS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause, (Disease or injury that initiated events Due to (or as a consequence of) Examiner ete has been signed by the attending physician and page 2 should be detached for use as the buriel-fransit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à ENCEPMA WPATHY 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes ■ XX No this certificate has 1 Yes 2 X No of or Attending Physician: after death. I Director: After this certifice tuneral director, 25. Was case referred to medical Be 26. Place of Death | Check only one examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 1 Yes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 XNatural 5 Pending м 1 ☐ Yes 2 ☐ No investigation 2 Accident filled in by the 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide To the Hospital of within 24 hours after to the Funeral Decompletely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 10-5-07 MD 1)5096 an 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SMAH ASSOCIATES, HOLLYWOOD MD 20636 GILL KAJ8INDER 31. Date filed (Month, Day, Year)

OCT 0 9 2007 32. Registrar's Signature State raction Registrar

			For	State of Mar	-			Mental Hy	giene		
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DHMH 17 Rev 1/2001

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Sequentially list conditions cause. Finer Underlying Equations a consequence of):    Due to (or as a consequence of):			0.1	disease or condition	Mé	tasi	tatic	Ga	istric Co	anc	er				Onset and Death
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FEMALE:   23b Was decedent pregnant in past 12 mgnths?   1   res   2   No   3   Dota of delivery   Month   Day   Year   1   res   2   No   3   Probably   4   Month   Day   Residence   6   Other (Specify)   1   res   2   No   1   res	9	be ey	田田田田田田田田田田田田田田田田田田田田田田田田田田田田田田田田田田田田田田田			0 (0) 40 4	oonooquonou (	,,.							
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 31 per dwr / 8872 10 9 07 vt. State of Maryland / Bepartment of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** October 0 William Lawrence Murphy 2007 12:00  $p^{M}$ Jr. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 4908 Brookwood Road Anne Arundel Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) April 12 1917 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours Days 10 M 2 F 102-03-6777 90 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Event. 10c. City, Town or Location 10a. State 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Director Anne Arundel Co. Brooklyn Park Md. 10f. Zip Code 10e Street and Number 10g. Citizen of What Country? 4908 Brookwood Rd. 21225 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Dryes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☑ No Specify: Specify: White Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Local 101 Elementary/Secondary (0-12) College (1-4or 5+) Carpenter's Union <u>Carpenter</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ٩ William L. Murphy Sr. Agnes Sexton 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda Galford, Daughter 4901 Brookwood Rd. Baltimore, Md. 21225 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cedar Hill Cemetery Oct 6, 2007 Balto. Md. 22. Name and Address of Facility Gonce Funeral Service P.A. 21. Signature of Funeral Service Licensee 4001 Ritchie Hgwy. Baltimore, Md. 21225 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): physician s the burial Records, P.O. Box 68760 Physician/Medical attending pl for use as t IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Vear 4☐Pregnant at time of death 5 ☐ Other (specify) ate has been signed by the page 2 should be detached 9∏Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1☐ Yes Division or Vital 25. Was case referred to medical examiner? funeral director 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No Certification: To 1 🔲 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation Injury 1 Yes 2 No hours after death. 2 Accident filled in by the 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 ho

To the Fun

completely 1 (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and 29d. Date signed (Month, Day, Year) 0063145 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) TILE PATUXENT PKWY COLUMBIA 0440

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

0 9 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 17 Certificate of Death 3. Time of Death Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** /Medical cility Name (If not institution 4c. County of Deatl **Examiner** C 5. Social Security Num Age (In yrs. last birthday Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 □ F 44 3733 Director FEB.7,1946 PENNSYLVANIA Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Director MD. N/A BALTIMORE 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 2208 GUILFORD AVENUE 21218 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black. White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify. þ Specify BLACK 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) PARAProfessional 12TH DEPT. EDUCATION 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be WILLIE MCCAIN ဥ GRACE WILLIAMS 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) TONYA RIVERS (daughter) 5935 LILLYAN AVE. BALTO, MD. 21206 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ P 4 ☐ Donation 5 ☐ Other (Specify) OCT.8,2007 3 ☐Removal from State MOUNT CREMATORY BALTIMORE, MD 21/Signature of Funeral Service Licensee 22. Name and Address of Facility
CALVIN B. SCRUGGS FUNERAL HOME 23a. Part1. Enter the disease, or complications that caused the learn shock, or heart failure. List only one cause on each line.  $\mathbf{E}$ PRESTON ST. BALTO MD. Do not enter the mode of dying, such as cardiac or respiratory arrest Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence off and Due to (or as a consequence of): attending physician Physician/Medical IF FEMALE: if yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Mann of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Injury 1 Yes 2 □ No 2 Accident 6 Could not be determined 3 Suicide

**Examiner** HospItal or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, this After within 24 hours after death To the Funeral Director:

Baltimore, Maryland 21215-0036

 Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. and tille of certifier

State

Registrar

Medical

person who completed cause of death (Item 23a) (Type, Print)

9

BAUTIMONE, MI

29d. Date signed (Month. Dav. Year)

d p > Permit. Pages 1 and 2 should be filed within 72 hours after death v	Department of Health and Mental Hygiene.		9
The law requires that the death certificate be executed	TO .	te has been signed by the attending physician and	

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Physicia	an	Decedent's Name (First, Middle,  Samuel	,	Milk				2	2. Date of Death Month Octobe		ear	3. Time o	30A M
/Medic Examin	9.0	4a. Facility Name (If not institution,				4b. City, Town, or	Location of	f Death	300000	4c. County of			
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Funeral			6. Sex 1 ☑ M 2 ☐ F	7. Age (In yrs.	last birthday) Yrs.	If Under 1 Year Months Days	If Under 2 Hours	Min.	3. Date of Birth (Month, Day,	Year)	Coun		or Foreign
Director		217-12-8161 Usual Residence of Decedent		83	113.				Sept. 2	6,1924	Mary	land	
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Ith an		Mrs. Shirley M		ife	1	23 Salisby				ce, Mary		,	.9
of Hear		20a. Method of Disposition			Place of Dispo cemetery, crei	sition (Name of matory or other plac	e) !	Da	ite 2	20c. Location - C	ity or To	wn, State	
Page ment ant: If		1 ☑ Burial 2 ☐ Cremation ☐ Donation 5 ☐ Other (Sp	pecify)	Gai	rrison	Forest V	.A. C	em. 1	.0/9/07	Owing	s Mi	ills,	MD
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mentall Hydiene. Important: If them 27 is marked other than "natural" or items 23a or 28a-f show important: If them 27 is marked other than "natural" or tems 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service I	icensee	7 ac		2. Name and Addres Duda-Ruck	Fune	ral F	Home of	Dundalk	Į Įi	nc.	
EUE O.	4	-920 Port1, Effer the disease, or	complications that	caused the dea	h Do not ent	7922 Wise					a 21	Approxima	ıte
Physician		shock, or heart failure. List of Immediate Cause (Final disease or condition	only one cause on e	0	sentic							Interval Be Onset and	Death
/Medical		resulting in death)	Due to	(or as a conseq		~						2 16	25/>
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at or / s after al Dire	Certification:	4 ☐ Homicide determi	build	ling, etc. (Speci	fy)	reet, factory, office			City or Town	, State)			
To the Hospital or Attending Physician: within 44 hours after death. To the Furneral Director: After this certifical completely filled in by the funeral director, for	Medical (	29a. Certifier (Check only one)	Examiner: On the b	e best of my kno basis of examina oner stated.	owledge, deat ation and/or in	h occurred at the tir vestigation, in my o	ne, date an pinion, dea	nd place, an ath occurre	nd due to the ca d at the time, d	ause(s) and man ate and place, a	ner as s	tated. o the cause	(s)
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5+1		30 Name and address of person of the North L. Ga.	.1 0 -	se of death (Iter	m 23a) (Type,	Print) AV	e P	BAIT	mova	MID	2	122	>
Sta	ate	31. Date filed (Month, Day, Year)	32.1	Registrar's Signa	ature		- 10	,,,,,,		1 1 1			
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07-07362 Wavne McGee

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene <u>2007 3</u>2233 1. For State Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ 1910 hrs Medical Examiner September 20, 2007 Wayne McGee 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 1c. County of Death 1500 blk Thames Street Baltimore 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or unk 5. Social Security Number unk 6. Sex If Under 1 Year If Under 24Hrs. 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Director 1X M Country) 2 F Yrs Dec 28, 1933 73 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d Inside City Limits unk unk unk 23a or 28a-f show notified at once. Yes 2 Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? unk unk IISA with 1 Funeral 11n k Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, permit. Pages I and 2 should be filed within 72 hours after death wi Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items injury or other traumatic eyent, the Medical Examiner must be White etc. Armied Forces? Never Married 2 Married Yes No f Yes, Give Year Divorced Yes 2 X No specify: Specify: white ð 16a. Decedent's Usual Occupation (Give kind of work done unk 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) unk Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) MD 21215-0036 unk 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) unk unk 19a. Informant's Name/Relationship (Type, Print ) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) O.C.M.E. 111 Penn Street Baltimore, MD 21201 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 20a Method of Disposition Date Baltimore, crematory or other place) Burial 2 Cremation 3 Removal from State Donation 5 X other Specify Signature of Euneral Service License 22. Name and Address of Facil State Anatomy Board 655 W. Baltimore Street Director Baltimore, MĎ 21201 art I. Enter the disease, or comp fons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** lure. List only one cause on each line Between Onset and /Medical Death Atherosclerotic cardiovascular disease Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. if any, leading to immediate Due to (or as a consequence of): Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last Physician/Medical AMENDED, 27, perME, g872, 10/11/07 TT X UNPENDED attending physician or use as the burial The law requires that the death certificate be Box 68760, 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Ectopic pregnancy Year Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 No 9 Unknown the s been signed by the should be detached o Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò Division of Vital Records, P. Yes 2 No 3 Probably 4 V Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy this certificate has be director, page 2 sh death? ✓ Yes 2 1 🗸 Yes 2 No To the Hospital or Attending Physicians within 24 hours after death. 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 1 Other; Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other: Scene this ဥ 1 ✓ Yes 28a. Date of Injury (Month, Day,Year) After 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 X Natural Pending Yes 2 Funeral Director: tely filled in by the 2 Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide or Town, State) determined (Specify) Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. **Medical** To the 1 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) OCME O.C.M.E September 21, 2007 30. Name and address of person who completed cause of de th (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Theodore M. King, Jr., MD.

**OCME 2006** 

31. Date filed (Month, Day, Year)

32 Registrar's Signature

State of Maryland / Department of Health and Mental Hygier [ ] Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 8 Amy 07 LLIAM mc 10 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 301 4b. City, Town, or Location of Death Examiner W FRAKLA BAltimore mo RAVENIWOOD NISG & REHAD CHR. 21201 If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 1 M 2 □ F 63 Yrs. 219-38-1296 Director 01-08-44 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "netural", or items 23a or 28e-f show treumatic event, the Modical Examinar mast be notified at MD 1√2 Yes 2 □ No Baltimore Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 501 W. Franklin Street 21201 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 21 No Specify: Specify: \$ black. 3 Widowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. ant: If item 27 is marked other than 10 0 disabled none 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lloyd McClain Adelaide Taylor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) int of Health a t: If item 27 is y or other tree Frances McClain/sister in law 639 Pitcher Street Baltimore , MD 21217 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Importent: If any injury or once. '4□Donation 5☒Other (Specify) in state 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street
Baltimore, MD 21201

Approximate permit. 21. Signaturi of Funeral S. rvice Ucensee Roma Ld S. Wadle esson Baltimore, MD Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, a heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Hepatocellular /Medical Due to (or as a consequence of): Examiner A 4's Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 20 Due to (or as a consequence of): Examiner ng physician and as the burial-transit or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: esn 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy ξ in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. I 1 ☐ Yes 2 ☐ No. the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Division of Vital Records, eq AIDS 3 Probably 1 Yes 2 No 4 Unknown page 2 should Be Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No certificate b 1 🗌 Yes 2 No 1 ☐ Yes funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 | Inpatient Other: 5 Residence 6 Other (Specify) 2 No 1 Tyes Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funerel Director: A completely filled in by the fu investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospitel Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only onel To the e of certifie 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and J 1)43386 10-2.07 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21217 Itonord, 1714 ELHEW Macy 4 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar

2007

Patient known as Minor James Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

edent	e street and number)	(In yrs. last bi	4	4b. City, Town	or Location of Dea	2. Date of De Month	Day	Year 2007	3. Time of Death
institution, give	- baltimor	(In yrs. last bi	4	4b. City, Town	or Location of Dec	1 - 7		,	
edent	ex 7. Age	(In yrs. last bi				ath	4c. 0	County of Death	1
1 [				Baltir		<b>y</b>			
	-1			If Under 1 Yea Months Day			th iy, Year) 10/13	9. Birth	nplace (State or Fore untry) MD
. County	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location								
		10c. City, Tov	wn or Locat		timore				10d. Inside City Lin
							10- 04-	en of What Cou	1 K Yes 2
Heights .	Avenue			10f. Zip Code	21215		rug. Citiz	USA	atiti y :
	12. Was Decedent Ev	ver in U.S.	13. Wa	as Decedent o		(Specify Yes or No erto Rican, etc.)	)- 1	4. Race - Amer	
2□ Married	Armed Forces? 1 ☐ Yes 2 A No If Yes, Give	)		res, specify Co ⊒Yes 2XXXN		ino Hican, etc.)		Black, White SpecifAfric	an American
Divorced	Year or Dates:	160							
Decedent's Edi	de completed)		(Give kir	nt's Usual Occ nd of work dor O NOT use reti	e during most of w	orking	100. KIII	d of Business/l	noustry
/ (0-12)	College (1-4or 5+)	,		fact	ory worker		Tat	te	
, Middle, Last)	unk				18. Mother's N	ame (First, Middle	, Maiden S	Surname) U	nk
Relationship (7)						Rural Route Numb 1stown, Mar		21133	îp Code)
on		20b. Place	of Disposit	tion (Name of	(200)	Date	20c. Loc	cation - City or	Town, State
emation 3 🔲 Other ( <i>Specify</i>	Removal from State			est Vet.		15/2007	Owings	s Mills,	Maryland
Service Licen		_	22. 1	Name and Add	ress of Facility	Wylie Fune Baltimore	ral Ho	ome. P.A.	
da	anna	)	63	8 N. Gil	mor Street	; Baltimore	, Mary	ylańd 21	217
ure. List only o	plications that caused the cause on each line	he death. Do	not enter	the mode of d	ying, such as card	ac or respiratory a	rrest,		Approximate Interval Between Onset and Death
_	a. Acute	myoca		l infect	ction				
	Due to (or as a	D	0	tiense					
ns, iate	Due to (or as a			MINERAL CONTRACTOR					0 (2)
1	o. Atrial 1	phillal	tion						
	Due to (or as a			. 41					
	d. Irlaila		wony	yapaun	1				
gnant <sub>I</sub>	23c. If yes, outcome p	of pregnancy					2	3d. Date of deli	very
ths?	1 ☐Live birth 2 4 ☐ Pregnant at ti			Ectopic pregna Other <i>(specify)</i>				Month	Day Year
	9□Unknown ——								
t conditions co	ontributing to death but	not resulting	in the unde	erlying cause	jiven in Part I.				the cause of death'
						-			
						24a. Was auto		24b. Were au prior to d death?	topsy findings availa completion of cause
o medical					Of Place of D	1□ Yes	2 <b>Y</b> No	1 ☐ Yes	2 No
H	Hospital: 1 Inpatien	nt 2 ER/O	Outpatient	3□ DOA	ther:	eath <i>(Check only only of the control of the contro</i>		□Other (Spec	cifv)
□Pending	28a. Date of Injury (Month, Day	y 28b.	Time of Injury	28c. In		28d. Describe			
investigation Could not be				M 1	JYes 2 No	100			
determined	28e. Place of injur building, etc.	y - At home, f . <i>(Specify)</i>	rarm, stree	et, tactory, offic	θ	28f. Location ( City or To	(Street and wn, State)	Number or Ru	ıral Route Number,
	ysician: To the best of								
	niner: On the basis of e	examination a							
Medical Exam				29c. Lice	nse number				
of certifier				111	^-		Unto	mor 6	7 . 2007
of certifier	MD			1660	-000		~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~	0	, ~~ ,
	of certifier	and manner stat	and manner stated.	and manner stated.	and manner stated.	and manner stated.	and manner stated.	and manner stated.	

07-07597

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2007 32236

Clarence Nicholson	State of Maryla	and / Department of He <i>Certificate of De</i>		giene	200	7 3223
	Legistrar  1. Decedent's Name (First, Middle, Last)	Certificate of De		Reg. I	3	3. Time of Death
Physician/ Medical Examiner	Clarence Nic	Cholson		Month Da September 2	y Year 7, 2007	1318 hrs
(	4a. Facility Name (if not institution, give street and no		ty, Town, or Location of Death		4c. County of Death	
	1504 Upshire Rd. Apt. 1 F	Ba	Itimore			
Funeral	5. Social Security Number 6. Sex		Inder 1 Year If Under 24Hrs.	8. Date of Birth (N	/M/DD/YYYY) 9. Birth Foreign	place (State or
Director	212-44-5678 1XM 2 ==	Yrs. Mc	onths Days Hours Min.	12-5-	1945 00	arolina
	Usual Residence of Decedent					10 d. Innida City Limito
w any	10a. State 10b. County	10c. City, Town or Location				10d. Inside City Limits 1  No
f sho	MD	Baltim	ore	140	0777	^
the Maryland a or 28a-f sh uffed at one	10e. Street and Number	0 (1-F) 10th	Zip Code	109.	Citizen of What Count	ryr
th the 23a o notifi	1504 Upshire	KCL Apt.	21218	oids Vec or No	14. Race - America	on Indian Plack
er death with t , or items 23a r must be not Funeral	11. Marital Status 12. Was De 1 Never Married 2 Married Armed I	orces? If Yes, sp	cedent of Hispanic Origin? ( Spe pecify Cuban, Mexican, Puerto F		White, etc.	all tilgiali, black,
er dez	1 Yes 3 Widowed 4 Divorced If Yes, Give Yes	2 No 1 Yes	No specify:		Specify: RI	ack
ural"	15. Decedent's Education (Specify only highest gra	ade completed) 16a. Decedent's Us	sual Occupation (Give kind of wo	ork done 16	bb. Kind of Business/In	dustry
12 hou "nat	Elementary Secondary (0-12) College	(1-4 or 5+) during most of	working life. DO NOT use retire	ed)	$C_{-}$	
5-0036 ed within 72 hour bygiene. other than "natt the Medical Exant Completed	104	(ONStr	ucton wal	1ch	CONST	uction
5-0 lied w Hygie I other	17. Father's Name (First, Middle, Last)	1 1	18.Mother's Name (	First, Middle, Mai	den Surname)	
121 I be fil ental F arked arked vent,		SON I	ress (Street and Number or Ri	UDr	inklee	7:a Onda)
imore, MD 21215-0036  Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.  Italiem 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at once.  To Be Completed by Funeral Director	19a. Informant's Name/Relationship (Type, Print )	Niece) 6211	Street and Number of Ri	urai Poute Numbe	of the MA	210 Code)
, M and 2 ealth e	20a. Method of Disposition	20b. Place of Disposition	(Name of cemetery,	Date 2	Oc. Location - City or 1	Town, State
Ore		from State crematory or other p	ace)	1elm	Dilia	MA
Baltimo permit. Page Department o Important: injury or ott	4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee	Lorrage	and Address of Fa	301	DAITIN	OR MID
Baltii permit. Departm Importa	P : (   = + = M =	1363 49	gho Colle	ye tu	b Min 2	rulias
Physician	23a. Part I. Enter the disease, or complications that		ode of dying such as cardiac or	respiratory arrest	, shock, or heart	Approximate Interval
Medical	failure. List only one cause on each line.	erotic Cardiovascular Diseas	e			Between Onset and Death
xaminer		a consequence of):				
	Sequentially list conditions, b					
ine	cause. Enter Underlying Cause	a consequence of):				
ted Insit Examiner	(I) is ease or injury that initiated	a consequence of):			-	
	d			-		
0, be execut sician and burial - tra	UNPENDED AMENDED	)				
6876( certificate ading physes as the b	23b. Was decedent pregnant in the	s, outcome of pregnancy	eath 3 Ectopic pregna	ncv	23d. Date of delivery  Month  D	eay Year
ox 6876 ant certificate attending phy for use as the l	nast 12 months?		(Specify)	,		
. Box 6876( the death certificate by the attending phys behed for use as the b Physician/Me	CALLED THE RESIDENCE OF THE PARTY OF THE PAR	nown				
s, P.O. irres that the signed by the detache	Part II. Other significant conditions contributing	to death but not resulting in the unde	rlying cause given in Part I.		2 No 3 Prob	
S, P uires th a signe d be d	Diabetes mellitus			24a. Was an		topsy findings available
cords, law requit has been s 2 2 should	()			autopsy perform	prior to c	ompletion of cause of
Records, The law require, ficate has been sig, gage 2 should be Completed				1 Yes 2		s 2 No
Division of Vital Records, P.O. Box 6876( To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Finneral Director: After this certificate has been signed by the attending physicianly filled in by the finneral director, page 2 should be detached for use as the ledical Certification: To Be Completed by Physician/Micedical Certification: To Be Completed by Physician/Micedical Certification:	25. Was case referred to medical examiner?		26.Place of Death (Check of DOA Other: Nursin			
F Vid	1 ✓ Yes 2 No	Inpatient 2 ER/Outpatient 3			esidence 6  Other	: Scene
n of ding Pl After funera		te of Injury nth, Day,Year) 28b. Time of Injury	/ 28c. Injury at Work?	200. Describe no	w injury occurred	
Sion Attender death death death death cetor:	2 Accident Investigation	ace of Injury - At home, farm, street, fa		28f Location (Str	reet and Number or Ru	ral Route Number, City
Division of Nopital or Attending Physical Attending Physical Property of Marcal Director: After the filled in by the funeral Certification: T	Suicide Could not be determined (Special		etory, office bending, etc.	or Town, Sta		
Hospital 24 hours Funeral tely fille	29a. Certifier Certifying Physician. To the h	pest of my knowledge, death occurred	at the time, date and place, and	due to the cause	(s) and manner as state	ed.
To the Hosp within 24 ho To the Fun completely (Medical C	one) 2 Medical Examiner: On the bas	is of examination and/or investigation,	in my opinion, death occurred a	t the time, date ar	nd place, and due to th	e cause(s)
To To Mec	and manne 29b. Signature and title of certifier	r stated.	29c. License number		29d. Date signed (Mo.	nth, Day, Year)
	Doma Wincorti, mis	l.	O.C.M.E.	l	October 5, 2007	
1	30. Name and address of person who completed ca	ause of death (Item 23a)	1			
5	Donna M. Vincenti, MD Assistant	Medical Examiner 111 Po	enn Street, Baltimore, M	D 21201		
State		Registrar's Signature	-			
Registra	OCT 0 9 2007	ORIGINAL				

**ORÍGINAL** 

			State of Maryland / Department of Health and M. State Amend Item 29d per dr., g872, 19/19/2014 Death	ental Hygier	2007	32237
8	* Physici		1. Decedent's Name (First, Middle, Last)	2. Date of Death Month	Day Year	3. Time of Death
	/Medic	_	HAROLD F. NASH		विक विकार	
).	Examin	er	4a. Fecility Name (If not institution, give street and number)  4b. City, Town, or Location of Death  Server Pa		4c. County of Death	
- 3		E.	CIEDESIS HEACIH CARE	8. Date of Birth		pplace (State or Foreign
1. S	Funeral Director		213-03-3327 10M 20F 89 Yrs. Months Days Hours Min.	(Month, Day, Yea	ar) Cou	yland
	and		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	Mary	Ď	MO ANNE ARMPEL SEVERNA PARK			1 Yes 2 No
	28a	Director	10e. Street and Number 10f. Zip Code	10g. (	Citizen of What Cou	untry?
	3a o		24 TRUCKHOUSE RD 21146		US	A
	death	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Spe Armed Forces? 15. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto Forces)	ecify Yes or No-	14. Race - Amer Black, White	
21215-0036	be filed within 72 hours after death with the Maryland tial Hygiene. od other than "natural", or Iteme 23a or 28e-f show event, It a Medical Examinar must be notified at	by	1 □ Never Married 2 □ Married 1 □ Yes 2 □ No If Yes, Give Year or Dates: 143–44	ritodri, oto.,		hite
2-0	72 hc	Completed	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of workin	ng unk 16b.	Kind of Business/l	ndustry unk
2	within ene. than "	mpl	Elementary/Secondary (0-12) College (1-4or 5+) life. DO NOT use retired)			
	e filed within al Hygiene. I other than 'vent, It's Me	ပိ	unk  17. Father's Name (First, Middle, Last)  18. Mother's Name	(First, Middle, Maid	len Sumame)	
and	id be fighted by the dot	Be		ie Mae Ha		
2	should be nd Menta marked imatic ev	10	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rura			ip Code)
Maryland	od 2 s lith an 27 ia 1 trau		Loretta Griest/friand 1333 Edna Road Pasaden		122	, , , , , , , , , , , , , , , , , , , ,
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked any injury or other traumatic er anca.			Date 20c.	Location - City or 1	Town, State
Baltin	permit. P Departme Importan any injur:		21. Signature of timeral Service icensee Procedure State Anatomy Board		altimore	Street
	E1550 I		23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac o			Approximate
			shock, heart failure. List only one cause on each line.			Interval Between Onset and Death
£.	Physician /Medical		disease or condition resulting in death)  a. CARDIOVASCULAR VISEASE			
F.	Examiner		Due to (or as a consequence of):			
		er	Sequentially list conditions, if any, leading to infinediate by the to (or as a consequence of):			
	uted	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events			
Ć	exector and and ital-tra	Exa	resulting in death) Last Due to (or as a consequence of):			
38760,	icate be executed physician and s the burial-transit	dlcal	d			
-			IS SCHALE.			
O. Box	he death certif the attending thed for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of deli Month	very Day Year
P.0	law requires that the de as been signed by the a 2 should be detached i		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacc	o use contribute to	the cause of death?
ds,	uires sign ld be	d by		1 ☐ Yes	2 □ No 3 □ Pro	obably 4 Unknown
COL	w require been si should l	lete		24a. Was an	24b. Were au	topsy findings available
Records,	The law ate has page 2	Completed		autopsy performed	prior to death?	completion of cause of
ā	lcien: T certificat rector, pa	ပို	25. Was case referred to medical 26. Place of Death	1 Yes 2 X	No IL Yes	2□ No
of Vital	Physician: r this certifica ral director,	ToB	examiner?	me 5 Residence	6 ∏Other (Spec	citv)
0	ding Ph. h. After thi funeral		27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at 2	28d. Describe how in		
Ö	Attending ir death. ector: After by the fune	atlo	2 Accident investigation M 1 Yes 2 No			
Division	after death after death Director:	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street City or Town, St		ural Route Number,
	Hospita 4 hours Funeral Bly filler	ledical C	29a. Certifier (Check only one)  1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and manner stated.			
	To the within 2 To the complet	Me	29b. Signature and the of certifier 29c. License number	_	Date signed (Montl	**
			1) i C'Williams D31136	Ser	otember 2	4, 2007
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  31. Date filed (Month, Day, Year)  OCT 0 9 2007  32. Registrar s Signature  33. Registrar s Signature	IDIS RAD	BATTIN	0RG, mp
NAC.	Sta	ite	31. Date filed (Month, Day, Year) OCT 0 9 2007  Results  32. Registrar a Signature	(		
ď	Regist	ar	OCI U 3 ZUUI JUREZUN ZU JURI			

		•	For State of State of Registrar	-	epartment of Health and Certificate of Death	Mental Hygier Reg. t	/ 1111 / 3//30			
			Decedent's Name (First, Middle, Last)			2. Date of Death Month	3. Time of Death			
	Physici /Medio		Elizabeth Jo Orr			Oct 5	2007 4-AM			
	Examir		4a. Facility Name (If not institution, give street and num		4b. City, Town, or Location of Deat	ation of Death 4c. County of Death				
				hab	Bel Him	Under 24 Hrs. 8. Date of Birth 9. Birtholace / State or Foreign				
	Funeral		1 M 2 TXF	'. Age (In yrs. last birtho	Months Days Hours Min.	(Month, Day, Yea				
b	Director		232-38-0522 Usual Residence of Decedent	80 Yrs		Apr. 9,	1927   West Virginia			
	yland		10a. State 10b. County	10c. City, Town o	r Location		10d. Inside City Limits			
	Mar Mar	Director	Maryland Harford	A	bingdon		1 ☐ Yes 2 XNo			
	or 28	Olre	10e. Street and Number		10f. Zip Code	10g. (	Citizen of What Country?			
	eth w		1401 Academy Garth		21009		USA			
36	s 1 and 2 should be filed within 72 hours after deeth with the Maryland Heelth and Mental Hygiene. Item 27 is marked other than "neturel", or items 23a or 28e-f ehow other treumatic event, the Madical Examiner must be positied at	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 ☑ Widowed 4 □ Divorced  12. Was Dece-Armed For 1 □ Yes If Yes, Giv Year or Da	2 🔯 No	<ol> <li>Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer</li> <li>Yes 2∑ No Specify:</li> </ol>	specify Yes or No- to Rican, etc.)	14. Race - American Indian, Black, White, etc.  Specify: White			
21215-0036	2 hou	ed	15. Decedent's Education	16a. D	ecedent's Usual Occupation	16b.	. Kind of Business/Industry			
215	within 72 ene. then "n	ple	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-	li	Rive kind of work done during most of wo fe. DO NOT use retired)	rking				
2	filed with Hygiene. sther than	Completed	12		Homemaker		Own Home			
nd	be file d oth	Be	17. Father's Name (First, Middle, Last)			me (First, Middle, Maio	len Sumame)			
χ	should ind Men	ဥ	Dovenor Dayton McGinnis			net Lilly				
Maryland	12 sh h and 7 is m treum	1	19a. Informant's Name/Relationship (Type, Print)	11	failing Address (Street and Number or R	0181,0000				
	of Heelth of Heelth litem 27 ir		Deborah Berenger / Daugh	20b. Place of D	401 Academy Garth, isposition (Name of		Maryland 21009  Location - City or Town, State			
o	ages nt of t: If it		1 Surial 2 ☐ Cremation 3 ☐ Removal from S 4 ☐ Donation 5 ☐ Other (Specify)	tate cemetery.	crematory or other place)		arkville, Maryland			
Baltimore,	permit. Pages Depertment of H Important: if its any injury or of		21. Signature of Funeral Service Licensee	Moreran			itkville, naryland			
B	Depermine on the property in the property is any in the property in the proper	. 4	I of M. When		22. Name and Address of Facility McComas Funeral H 1317 Cokesbury Rd	ome, P.A.	Maryland 21009			
			23a. Part Enter the disease, or complications that ca shock, or heart failure. List only one cause on ea	used the death. Do not			Approximate Interval Between			
110	Physician		Immediate Cause (Final disease or condition		wise Dona 6		Onset and Death			
1	/Medical		resulting in death)	or as a consequence of)	INC DEMENT	a				
	Examiner		Sequentially list conditions, b.	Failure	to there					
	P #	Iner	if any, leading to immediate Due to (cause. Enter Underlying	or as a consequence of)						
	ecute end -trans	Examiner	Cause (Disease or injury that initiated events c	or as a consequence of)						
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587		edical	d							
P.O. Box	res that the death certification of the attending for the detached for use as	Physician/M	in the past 12 months?	come of pregnancy rth 2  Fetal death ant at time of death wn	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delivery Month Day Year			
	requires that the been signed by th hould be detache	F.	Part II. Other significant conditions contributing to de	ath but not resulting in th	ne underlying cause given in Part I.	23e. Did tobacc	co use contribute to the cause of death?			
rds	quires n sign	d by				1 Tes	2 ☐ NO 3 ☐ Probably 4 ☐ Unknown			
Records,		Completed				24a. Was an	24b. Were autopsy findings available			
Re	e h de h	E				autopsy performed 1 ☐ Yes 2 ☐	? death?			
Ita	icien: T	0	25. Was case referred to medical	1867-2	26. Place	ath Check only one	NO LENG			
of Vital	g v d	To B	examiner? 1 Yes 2 Hospital: 1 I	npatient 2 ER/Outp	atient 3 DOA Other: Nursing	Home 5 Residence	e 6 ☐ Other (Specify)			
0	ng Pt fter th		27. Manna f Death 1 Natural 5 ☐ Pending (Month	f Injury 28b. Tim n, <i>Day Year)</i> Inju		28d. Describe how in	njury occurred			
sio	Attending r death.	catle	2 Accident investigation		M 1 Yes 2 No	ļ				
Division	or Atl	Certification:	determined 289. Place	of Injury - At home, farm g, etc. <i>(Specify)</i>	, street, factory, office	28f. Location (Street City or Town, St	t and Number or Rural Route Number, tate)			
<u> </u>	lospital hours a unerel [		29a. Certifier 1 Certifying Physician: To the	hast of my knowledge of	leath occurred at the time, date and plac	e and due to the cause	e(s) and manner as stated			
	To the Hospital or Attending Phwithin 24 hours after death. To the Funeral Director: After the completely filled in by the funeral	edical	(Check only 2 Medical Examiner: On the ba	sis of examination and/	or investigation, in my opinion, death occ	urred at the time, date	and place, and due to the cause(s)			
	To th To th compl	Me	29b. Signature and title of certifier		29c. License number	29d.	Date signed (Month, Day, Year)			
	/		Y (Yllam OM)	Lun	PISSA	3 00	tober 5, 2007			
	6		30. Name and address of person who implified caus	of death (Item 23a) (Ty	/pe, Print)	Street	1 0			
	)		Manuel Lozatio	MP	therdeen,	Mark	and 21001			
	Sta Regist	ate	31. Date filed (Month, Day, Year) 32. R	egistrar's Signature	ossil .					
	negist	rai	00100 2001	100 100						

07-07660 Sharon Otten

Sharon Otten	State of Maryland / Department of Health and Mental Hygiene  1- For State Reg. No. 2007 322	3
Physician/	1. Decedent's Name (First, Middle,Last)  2. Date of Death  Month  Day  Year	Ť
Medical Examine	Sharon Otten  September 30, 2007  4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death  4c. County of Death	$\dashv$
,	Sinai Hospital Baltimore City N/A	$ \bot $
Funeral Director	5. Social Security Number 217-74-9547  6. Sex 7. Age (In yrs. last birthday) 1 Under 1 Year 1 Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign Months Days Hours Min. August 3, 1957 Country) Maryla	nd
any	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limi	ts
<b>k</b>	Maryland N/A Baltimore 1XXYes 2 N	ło
the Maryland a or 28a-f sh lifted at once	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?	$\neg$
with the s 23a o e notifi		$\dashv$
r death with or items 23 cmust be no	1 Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc.	
nrafter nral", miner	3 Wildowed 4 Authorocce or Tates: 1 Tes 524 No specify: Specify: WILLC	$\dashv$
Baltimore, MD 21215-0036  pemit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.  To Be Completed by Funeral Director	Elementary/Secondary (0-12) College (1-4 or 5+)  9+h  College (1-4 or 5+)  Folder/ Assembly  Book Boundary	-
1 within grene.	9th FOLGET/ ASSEMBLY BOOK BOURGALY  17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Maiden Surname)	
215. be filed antal Hy rked of	Willard Clyde Mort, Jr. Betty M. Cunningham	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than injury or other traumatic event, the Medica To Be Comple	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  19c. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  19d. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  19d. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  19d. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)	16
e, M 1 and 2 Health item 2	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State	-
Pages Pages nent of ant: If	4 Donation 5 Other Specify: Metro Crematory 10/5/2007 Catonsville, Maryla	nd
Balt permit. Departr Import	21. Sign there of Funeral Service Microsee  22. Name and Address of Facility Burgee-Henss-Seitz Funeral Home, Inc. 3631 Falls Road Baltimore, Maryland 21211	
Physician	23a. Pax/I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Inter-	
/Medical xaminer	Immediate Cause (Final disease a. Atherosclerotic cardiovascular disease Death	
	or condition resulting in death)  Due to (or as a consequence of):  Sequentially list conditions,  b.	
niner.	if any, leading to immediate Due to (or as a consequence of):  cause. Enter Underlying Cause  Chicago additional field and Consequence of Con	
the death certificate be executed by the attending physician and ched for use as the burial - transit  Physician/Medical Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):  d.	
be exection a sician a sician a curial - 1	WINDED  AMENDED  #23a, PII. 27, perME, g873, 11/2/07 TT  IF FEMALE:  23c. If yes, outcome of pregnancy  23d. Date of delivery	
ing Physician: The law requires that the death certificate be executed.  After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial - transit in To Be Committed by Physician/Medical Ex	FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months?	
Sox 6 leath ce attend for use	4 ☐ Pregnant at time of death 5 ☐ Other (Specify)  1 ☐ Yes 2 ☐ No 9 ✔ Unknown	
O. E at the d at the etached		$\neg$
ls, P.( quires that an signed ald be det	Chronic alcoholism 1Yes 2No 3Probably 4 ✔ Unknow 124a. Was an124b. Were autopsy findings availa	
Records, The law requires rate has been sig page 2 should be	autopsy performed? death?	
ul Re m: The ertificate tor, pag.	25 Man and a marked to marked to marked to the second to t	-
Vita hysicia this ce	examiner? 1 Ves 2 No  Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA  Other4 Nursing Home 5 Residence 6 Other:	
	27. Manner of Death 28a. Date of Injury (Month, Day,Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred	
Division o  Division o  To the Hospital or Attending within 24 hours after death. To the Founcial Director: After completely filled in by the fune	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, Cor Town, State)	ity
Di Spital of hours a meral I	4 Homicide determined (Specify)  29a. Certifier A Continue To the best of my knowledge, death occurred at the time date and place, and due to the cause(s) and manner as stated	_
Divis  To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)	
To Col	and a second	
W . A	Theodon My Ty & They was O.C. IVI.E. OCCODER 1, 2007	
16x00h	30. Name and address of person who completed cruise of death (it. m 23a)  Theodore M. King, Jr., MD. Assistant Medical Examine 111 Penn Street, Baltimore, MD 21201	
Stat Registra	(III) II II COO! Discours a No.	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** Asbury Reginald Pulley, Tr.

4a. Facility Name (If not institution, give street and number)

4 11:40 AM 25 2007 /Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner Good Samaritan Hospital Baltimore If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 19 M 2 □ F Days 6 Director 216-44-6312 Maryland 8-19-1947 Usual Residence of Deceder permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural" --- any injury or other traumatic everage. 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 Ves 2 No **Funeral Director** Baltimore MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code a1239 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify Completed by Black 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Mechanic iath 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) To Be Pulley trances Henson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bishop Doral

20a. Method of Disposition 422 Milford Mill Ad Pikesville MD alao8
ace of Disposition (Name of Date 200. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Greenmant Crematory 10.9.2007 Baltimore MD

22. Name and Address of Facility Cremation Services 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licenses 5151 Baltimore Nat'l Pike Baltimore, MD 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Constrictive Pericarditis wk disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner irrhosis Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last requires that the death certificate be executed and use as the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. attending physician Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? 1 ☐ Yes 2 ☐ No Month 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by No 3 Probably 4 Unknown ailure, Thromboats penia 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an Pariphral Vasc. diseale autopsy performed? Yes 21 No 1☐ Yes or Attending Physician; 25. Was case referred to medical 26. Place of Death (Check only one) Medical Certification: To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes No 📆 🗷 P Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) After thi funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending investigation 1 □ Yes 2 □ No ours after death.
neral Director: A
filled in by the fu 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital o within 24 hours aff To the Funeral D 29a. Certifier Vi Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier RAZORY Res-000 10/05/2007 M.D.

Registrar

State

AMIR KAZORY,

31. Date filed (Month, Day, Year)

Baltimore, MD 21239

Loch Raven Blad

32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

			1 - For State Registrar	State of Mary		artment of F		nd Mental Hy	giene Reg. N2 0 0 7	32241
	Physici /Medic		1. Decedent's Name (First, Middle, La. Ru TH	•		P	EET	2. Date of D Month	Day Yea	
	Examin		4a. Fecility Name (If not institution, giv	e street and number)		4b. City, Town, o		f Death	4c. County of D	eath
			Bon Secours Ho		ven la et hirthday)	Baltin		24 Hrs. 8. Date of B	N/A	Pirthelese (State or Fourier
L	Funeral Director	_	218-22-3015	□M 2DF 86	yrs. last birthday) Yrs.	Months Days	Hours	Min. (Month, D	ay, Year)	Birthplece (State or Foreign Country) rginia
	Maryland	tor	Usual Residence of Decedent  10a. State Maryland  10b. County N/I	10	c. City, Town or Lo Balt	ocation 1More				10d. Inside City Limits 12 Yes 2 No
	n with the 23a or 28s	ai Director	10e. Street and Number 4106 Boarman	Avenue		10f. Zip Code 2121	5		10g. Citizen of What	Country?
036	within 72 hours atter death with the Maryland ene. Then "neturel", or items 23a or 28a-f show the Modical Examinal must be notified at	by Funerai	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent Ever Armed Forces? 1  Yes 2 No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cub. 1 Yes 2 No	dispanic Orig an, Mexican, Specify:	in? (Specify Yes or N Puerto Rican, etc.)	o- 14. Race - A Black, W Specify:	merican Indian, hite, etc. Filan Amela
1215-0036	within 72 ho ene. then "netur ne Medical	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)	de completed) College (1-4or 5+)	(Give	dent's Usual Occup kind of work done DO NOT use retired	oation during most d)	of working	16b. Kind of Busine	,
_	should be filed nd Mental Hygis marked other umatic event, the	To Be Co	12th grade 17. Father's Name (First, Middle, Last, Robert C. But		1.75 5.2			r's Name <i>(First, Middle</i> h Handsh	e, Maiden Sumame)	
, Mar	nd 2 s		19a. Informant's Name/Relationship ( Rena E. Peete-C	Slover/Dau	ghter 3	711 Col		Drive B	altimore	
Baltimore,	Page net o int: If iry or		20a. Method of Disposition  1 □ Burial 2 □ Cremation 3 □  '4 □ Donation 5 □ Other (Special	Removal from State	Woodlaw	natory or other place n Cemet	ery			, Maryland
Ba	permit. Departn Importe any inju		21. Signature of Funeral Service Licey	lne						neral Home Md 21215
í	Physician /Medical	-	23a Print. Enter the disease, or com shock, or hant failure. List only Immediate Cause (Final disease or condition resulting in death)	one cause on each line.	death. Do not en	A	ng, such as o	cardiac or respiratory	arrest,	Approximate Interval Between Onset and Death  2 DAY
Ļ	Examiner	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Each originary cause (Disease or injury that initiated events resulting in death) Last	b. ACU  Due to (or as a co	TE 2E presequence of):  105CL2 prisequence of):	NA2 FOTIC	FAI	LURE ART DI	SEASE	1 DAY UNKNOWN
.O. Box 68	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of p 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3	Ectopic pregnanc	у		23d. Date of Month	delivery Day Year
rds, P.	w requires that been signed I should be det	[출	Part II. Other significant conditions of DIABETES		4	nderlying cause giv	ven in Part I.			e to the cause of death?  Probably 4 AUnknown
Reco	The law re te has bee age 2 sho	Completed	HYPERTEN CEREIBRO		AR D	15 FAS	7.2.		opsy prior death	autopsy findings available to completion of cause of
ital		Bec	25. Was case referred to medical examiner?			7567/00		of Death (Check only		55 20110
Division of Vital Records,	Attending Physicien: The laving death. cector: After this certificate has by the funeral director, page 2	은	1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Ye	2 ER/Outpatier 28b. Time o Injury	f 28c. Injur	4 🛄 1401	28d. Describe	idence 6 Other (S how injury occurred	pecify)
Divisi	- 00	Certification;	3 Suicide 6 Could not be determined			reet, factory, office			(Street and Number or own, State)	Rural Route Number,
	To the Hospitel or At within 24 hours after of To the Funerel Direct completely filled in by	edicai	(Check only 2 Medicel Exer	nysician: To the best of m niner: On the basis of exa and manner stated	amination and/or in	vestigation, in my	opinion, deat	d place, and due to the th occurred at the time	, date and place, and	due to the cause(s)
	With Tot	Σ	29b. Signature and title of certifier	Stofoly	MD.	29c. Licens	3301	>	29d. Date signed (M	onth. Day, Year)
	3		30. Name and address of person who	completed cause of death	(Itom 23a) (Tuno	Ociet) 47 . m	1 15	C1.10 D 2 1	wind P.	
	Sta Registi		31. Date filed (Month Day, Year)	32. Registrar's	Signature Apart	K)	, , ,	- 1 4500 11 100	, , , , , ,	,21223,

			For State Registrar	State of Maryland	-	artment of H			2007	32242
	Physici	20	1. Decedent's Name (First, Middle, La	·				2. Date of Death Month	Day Year	3. Time of Death
	/Medic			lliam Perryma	n, J			October	7, 200	
	Examin	er	4a. Facility Name (If not institution, give 301 Church Rd.			4b. City, Town, or	Location of De sterst		4c. County of Dea	
	-		5. Social Security Number 6. S		st hirthday)	If Under 1 Year	If Under 24 H		Balti	
	Funeral Director	:	212-48-2075	©XM 2□F 59	Yrs.	Months Days		in. Aug • 25	.1948 M	thplace (State or Foreign ountry)
	P .		Usual Residence of Decedent							
	ehov	7	MD Balti		Town or Lo					10d. Inside City Limits 1 ☐ Yes ※XXNo
	the M	Director	10e. Street and Number	.more K	eist	erstown		100	g. Citizen of What C	
	72 hours after death with the Maryland natural", or Items 23a or 28a-f ehow disal Examinat must be cotified at	ă	301 Church Ro	3 .		,	136	100	U.S.A	
	death ms 23	Funeral	11, Marital Status	12. Was Decedent Ever in U.S.	. 13.			(Specify Yes or No- erto Rican, etc.)	14. Race - Ami	erican Indian,
9	after or ite	Fur	1 Never Married XX Married	Armed Forces? 1 ☐ Yes XXNo		f Yes, specify Cuba 1□ Yes 🄀 No	n, Mexican, Pu Specify:	erto Rican, etc.)	Black, Whi	te, etc.
93	iral',	d by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 1 105 22E3 NO	эрөспу.		Specify: W	nite
5-0	"natu	Completed	15. Decedent's Ed (Specify only highest gra		(Give	dent's Usual Occupa kind of work done o	furing most of v	working 16	6b. Kind of Business	/Industry
12	within ene. then "	gmg	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT use retired. Painter	)		Baltimo:	re County
9	filed Hygi ther int, I		17. Father's Name (First, Middle, Last,	)			18. Mother's N	Name (First, Middle, Ma		ic country
Maryland 21215-0036	should be nd Mental marked o	To Be	Harvey Willia	m Perryman,	Sr.		Bett	y Mae Bla	ackburn	
lary	s i end 2 should i Health and Men Item 27 le marke other traumatic	_	19a. Informant's Name/Relationship (	•		-		Rural Route Number, (		
≥,	end seath m 27		Joan V. Perryma				Rd. Re	****		/land 21136
Baltimore,	<b>0</b> 0		20a. Method of Disposition XXBurial 2 Cremation 3	Removal from State 20b. Place Cent F.V	ce of Dispo netery, crei Prar	sition (Name of natory or other place een 1 Garden	θ)	Date 20	c. Location - City or	Town, State
Εij	it. Partmen		4 □ Donation 5 □ Other (Specifical Street Licenters)	w) Mem	ŏrťā	1 Garden	s   10	0/10/07_	Finksbu	g, MD
Ba	permit. Pag Department Important: I any injury o		21. Signature of Suntial Sauce Lices	1111111						hapel P.A. 1s,MD21117
			23a. Part1. Enter the disease, or com	plications that caused the death.						Approximate
	Physician		shock, or heart failure. List only Immediate Cause (Final	a Metastat	tic	60 h 6 1 h	(	1 4401-61	_ )	Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	Due to (or as a consequent		Carcino	me (	105631		
	Examiner		Sequentially list conditions	b						
	od ii	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (brias a eoneequal	nea off;					
	and I-tran	xam	that initiated events resulting in death) Last	c. Due to (or as a conseque	nce of):					
8760,	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Cal E		4						
	ificate g phy as the	P		_ d.						
Box 6	eath certific attending p for use as	M/U	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnance 1 ☐ Live birth 2 ☐ Fetal de		Ectopic pregnancy			23d. Date of de	livery
	e deal	Physician/M	in the past 12 months? 1 Yes 2 No	4☐Pregnant at time of deal		Other (specify)			Month	Day Year
P.O.	at the ded by the a	Phy	9 ☐ Unknown  Part II. Other significant conditions of			- d - k t		Oga Didasha		o the cause of death?
ds,	signed by the det	d b	C o		ing in the u	idenying cause give	m m Fan I.			robably 4 Minknown
Š	w require been si should b	ete			,					
Re	The tav	Completed						24a. Was an autopsy performe	prior to death?	utopsy findings available completion of cause of
ta	Iclan: Th certificate ector, pag	Be Co	25. Was case referred to medical				26 Place of F	1 ☐ Yes 2-5 Death (Check only one)	30No 1 ☐ Yes	3 2□ No
Ξ	Physician: this certific al director,	To B	examiner? 1 ☐ Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ EF	R/Outpatier	t 3 DOA Othe	100	Home 5 Residen	ce 6 □Other (Spe	ecify)
0 _	Attending Physician: r death. sctor: After this certifict by the funeral director,		27. Manner of Death 1 Matural 5 □ Pending	28a. Date of Injury (Month, Day Year)	8b. Time of	28c. Injury Work		28d. Describe how		
Sio	sath. or: A the fu	catle	2 Accident investigation 3 Suicide 6 Could not be				res 2 □No			
Division of Vital Records,	i g th o	Certification:	4 Homicide determined		e, farm, str	eet, factory, office		28f. Location (Stre City or Town,	et and Number or R State)	ural Route Number,
ت	To the Hospital or Attsnowithin 24 hours aftar death To the Funeral Director: completely filled in by the		29a. Certifier 12 Certifying Ph	sysician: To the best of my knowle	edge, death	occurred at the time	e, date and ola	ace, and due to the cau	se(s) and manner a	s stated.
	24 h	edical	(Check only 2   Medical Examone)	niner: On the basis of examination and manner stated.	n and/or in	vestigation, in my op	inion, death oc	ccurred at the time, date	e and place, and du	e to the cause(s)
	To the within To the comp	W	29b. Signature and title of certifier			29c. License			1. Date signed (Mon	
	4.		I bound se	wort, 14.0.		D /	5-5-1-5		10/4.	7
6	Y		30. Name and address of person who	completed cause of death (Item 2 + 2 , 2 , 3 )  32. Registrar's Signatur	3a) (Type,	Print) Should 1	) L. J	1 to #340	Owings	M:115 md. 211,
	Sta	te	31. Date filed (Month, Day, Year)	32. Resstrar's Signatur	гө	1	-			
	Registr	ar	OCT 0 9	2007 Deserve 1	15 1	port	·			
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07-07643 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Katherine Marie Phillips State of Maryland / Department of Health and Mental Hygiene 2007 32243 1- For State Certificate of Death Reg. No. Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time of Death Physician/ Month Day September 29, 2007 Katherine Marie Phillips 1245 hrs Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 756 Frederick Road Baltimore County Catonsville 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year If Under 24Hrs. **Funeral** 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Months Days Hours Director Country) 2X F M 43 Yrs 2, 1964 Aug. Unknown Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 1 Yes 2 X No permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once. Baltimore Lansdowne Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3081 Bero Road 21227 United States Funeral 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 X Never Married 2 Married 2X No Yes Specify: White f Yes, Give Yea Widowed Divorced Yes 2 X No specify: ð 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Syms Clothing Elementary/Secondary (0-12) College (1-4 or 5+) MD 21215-0036 10 Sales Clerk Store 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Frank Thomas Jr. Carol Leanne Phillips Be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carol L. Phillips - Mother 2908 Bero Road, Lansdowne, MD 21227 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 20a. Method of Disposition Baltimore, 2 X Cremation 3 Removal from State Westemakerenthedace) 10-8-2007 Odenton, MD Crematory 22. Name and Address of Facility Ambrose Funeral Home, 2719 Hammonds Fry Rd., Lansdowne, MD 21227 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line /Medical Death Narcotic (methadone) intoxication and drug use Immediate Cause (Final disease caminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Examiner if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit Physician/Medical X UNPENDED ned by the attending physician detached for use as the burial perME.2872. 28a-f Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Fetal death Dav Year past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 V Unknown g Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? è Yes 2 No 3 Probably 4 ✔ Unknown Completed plnous 24b. Were autopsy findings available 24a, Was an prior to completion of cause of autopsy certificate has performed? death? 2 No ✓ Yes 2 No To the Hospital or Attending Physician: within 24 hours after death. 26.Place of Death (Check only one) funeral director, 25. Was case referred to medical Be Hospital: Other<sub>4</sub> After this Inpatient 2 ER/Outpatient 3 Nursing Home 5 Residence 6 ✔ Other: Scene 1 🗸 Yes 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day, Year 28b. Time of Injury 28c. Injury at Work? Certification: Natural Yes 2 X No Pending unk Funeral Director: the Fnd 9/29/2007 Fnd 12:20 p.m. Accident Investigation filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 6 X Could not be 756 Frederick Rd. Catonsville, MD determined Homicide found in parking lot 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a)

and manner stated

32 Règistrar's Signature ORIGINAL

Assistant Medical Examiner

2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

O.C.M.E

OCME

111 Penn Street, Baltimore, MD 21201

29d. Date signed (Month, Day, Year)

September 30, 2007

Medical

State Registrar

29b. Signature and title of certifier

Theodore M. King, Jr., MD.

To the

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician**  $\mathbf{P}^{\mathsf{M}}$ CAROLE ANN PRICE 6:51 October 2 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Greater Baltimore Medical Center Baltimore Towson If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral Months Days 06/26/1941 1 M 2 K MARYLAND 216-38-6981 66 Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Man Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sh any Injury or other traumatic event, the Medical Ex miner must be notified. WHITE HALL 1 ☐ Yes 2 No MD BALTIMORE Director 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 21161 USA 20907 WEST LIBERTY RD Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 2 No 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: WHITE 5 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12YRS College (1-4or 5+) HOUSE CLEANING HOUSE CLEANING 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be VIOLA E. SHEELER THEODORE R. MICHAEL 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2785 PARK RD BALDWIN, MD. 21013. ROBIN PRICE (DAUGHTER) 20b. Place of Disposition (Name of cemetery, crematory or other place)
WEST LIBERTY 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10/6/2007 WHITE HALL, MD. 21. Signature of Fureral Service Licens W. JENKINS & SONS CO. YORK RD MONKTON, MD. 21111. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betw Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician PANCREANC /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner death certificate be executed Due to (or as a consequence of) physician at the burial-t Box 68760. Physician/Medical as attending IF FEMALE: use a 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy in the past 12 months? for Month Day Year 5 ☐ Other (specify) P.O. ed by the a 9☐Unknown 9 ☐ Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown as been s Completed 24a. Was an autopsy performed?
1□ Yes 2. No 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No certificate has page Division or Vital Physiclan: director. 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Yes ၉ 1 Inpatient 2 ER/Outpatient 3□ DOA this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred within 24 hours after death. To the Funeral Director: After t Certification: the Hospitai or Attending 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ģ 4 Homicide filled in 29a. Certifier 🛮 🗶 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day,

Year)

OCT 0 9

ORIGINAL

6535

3 Registrar's Signature

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** LARGARET 06:30 PM FOOR STRKK /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MARYLAND MODICAL CENTER Juliazità oc If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 ☐ M 2 🖫 F Director 219**-**16-3028 82 10, 1924 Oct. Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nnent of Health and Mental Hygiene. and it filem 27 is marked other than "natural", or items 23a or 28a-f show ant; if item 27 is marked other than "natural", or items 23a or 28a-f show uny or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County 1 ☐ Yes 2 XNo Director Harford Air Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or 3 must be n 300 Sunflower Dr. Apt. 283 21014 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Tes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify. þ 3 ₩idowed 4 Divorced White Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Registered Nurse Health Care 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Frank William Krebs Sr. Maria Hannah Schwarz ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u> Ellen Petrick/Daughter-in-law</u> 600 Emmy Dee Dr., Bel Air, MD 21014 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of F Important; If Ite any injury or ot. 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Hilltop Service Corp. 10-10-07 4 □ Donation 5 □ Other (Specify) Towson, Maryland of Funeral Service Licensee 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Rd., Abingdon, Maryland 21009 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) SUDJACALDUS S **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of): P.O. Box 68760. physician Physician/Medical the attending pl IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1☐Yes 2☑No Day Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) been signed by the should be detached 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records. Completed by 2₽ No 3 Probably 4 Unknown 1 Tyes 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ 0 24a. Was an certificate has birector, page 2 s autopsy 1∐ Yes 2ABANo To the Hospital or Attending Physician: 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Hospital: 1 Appatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 → No ို 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No s after death. 2 Accident Could not be determined 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

within 24 hours aft

To the Funeral Di

completely filled in

State Registrar

Medical

DHMH 17 Rev 1/2001

(Check only one) 29b. Signature and title of

certifier

CHESLER

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Gren 32 Registrar's Signature

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

07-07711

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Price	Re	State of Maryland / Department of Health and Mental Hygiene For State Certificate of Death Reg.	
Physician/ al Examine		Decedent's Name (First, Middle,Last)  2. Date of Death Month DONALD BRUCE PRICE October 2, 2	3. Time of Death 2007 2021 hrs
	4	Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death	4c. County of Death Cecil
Funeral	5		MM/DD/YYYY) 9. Birthplace (State or
Director		212-98-3166 1X M 2 F 26 Yrs. Months Days Hours Min. May 18	, 1981 Country Maryland
any	_	Sual Residence of Decedent  Da. State 10b. County 10c. City, Town or Location	10d. Inside City Limits
Maryland 28a-f show d at once.	<u> </u>	Maryland Cecil Elkton	1 Yes 2 X No
the Maryland or 28a-f sh iffed at once Director	3 1	of Steel and Hamber	. Citizen of What Country?
		Manital Status     12. Was Decedent Ever in U.S.     13. Was Decedent of Hispanic Origin? (Specify Yes or No-	JSA 14. Race - American Indian, Black,
or items 23		Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	White, etc.
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ould be fill d Mental I s marked lic event,		Henry McDonald Price Lila Marie Mi. 9a. Informant's Name/Relationship (Type, Print ) 19b. Mailing Address (Street and Number or Rural Route Numb	
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permit. Pages 1 ar Department of Hee Important: If ite injury or other tr		Glen Haven Mem. Park   10-8-07	Glen Burnie, Marylan
permil Depar Impo injury	1	agnature of Funeral Service Licensee 222 Name and Address of Facility MCComas Funeral Home, P.7 1317 Cokesbury Road, Abir 3a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrespiratory  A. nodon. Maryland 21009	
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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificath is sheen signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transitional Contribution To Bo Completed by Diversing Madical Ex		FEMALE:  8b. Was decedent pregnant in the past 12 months?  1 Live birth 2 Fetal death 3 Ectopic pregnancy 5 Other (Specify) 9 Unknown	23d. Date of delivery  Month Day Year
that the greed by the detache	≥	are in Other Significant Contained to Contained in the Co	pacco use contribute to the cause of death?  2 No 3 Probably 4 V Unknown
In or Attending Physician: The lar requires that the death certifical ris after death.  al Director: After this certificathes been signed by the attending pled in by the funeral director, page 2 should be detached for use as the death of the funeral director, page 2 should be detached for use as the financial of the funeral director.	Completed	24a. Was a autops perfor	prior to completion of cause of death?
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hours and hours y filled		4 Homicide determined (Specify)  9a. Certifier A Continuor Rhypotatory. To the host of my knowledge, death occurred at the time, date and place, and due to the causi	o(s) and manner as stated
the Hin 24 the Fu	ल	Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date at the ti	and place, and due to the cause(s)
To To Con	ĕ	and manner stated.  29b. Signature and title of certifier  29c. License number  OCME	29d. Date signed (Month, Day, Year)
A	- 1	Theodore M. hing JR, was	October 3, 2007
401			
new )		Name and address of person who completed cause ( eath (lift m 23a) Theodore M. King, Jr., MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	

Amend Items 24a,25,26,27,29a per dr. 887,10/09/07dhb 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) September 24 2007 12:30 pt **Physician** Thomas R. Powell /Medical 4b. City, Town, or Location of Conference Co 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Somerset Manor Manokin Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 ₹ M 2 □ F 51 Yrs Maryland Director 214-66-7988 Usual Residence of Decedent death with the Maryland 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If Item 27 is marked other than "natural; or Items 23a or 28a-f show any njurry or other treumatic event, the Madical Examination and De notified at once. 10a. State 10b. County 10c. City, Town or Location 1 ☐ Yes 2√ No Director MD Princess Anne Somerset 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21853 USA 11974 Edgehill Terrace Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ [XNo If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: white ģ 3 ☐ Widowed 4 🎇 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry unk 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) laborer 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Katherine Marie Owens George Thomas Powell 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 318 S. Haven Avenue Salisbury, MD 21804 Tammy Powell/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☑Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Ronald S. Wade, Director State Anatomy Board 655 W. Baltimore Street 23a. Part NEnter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 18840819 **Physician** /Medical Due to (of as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine attending physician and for use as the burial-transit law requires that the death certificate be executed Due to (or as a consequence of): Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant ned by the atter e detached for u 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9☐ Unknown 9 Unknown ate has been signed page 2 should be de Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? this certificate 2 No 2X No 1 TYes Division of Vital 25. Was case referred to medical examiner? funeral director. Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 27. Manner of Death 28d. Describe how injury occurred After t 5 Pending investigation s after decreal Director: Alte 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours a

To the Funeral C

completely filled 1 \*\*Ecertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 \*\*Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 10 Day ath (Item 23a) (Type, Print) Z 32. Registrar 9 Signature State Registrar

towell, Thomas

		For State Registrar	State of	of Marylar		artment of H			giene 0	07	32248	
* **	Decedent's Name (First, Middle, Last)							2. Date of Dea	ith Day	Year	3. Time of Death	
Physicia /Medic		Margaret 1	Marsden 1	Bailey	Pawlo	wski		Sept		2007	9:00P M	
Examin		4a. Facility Name (If not institution	n, give street and nu	ım <i>ber)</i>			Location of Death	1		nty of Death		
		Bradford O				Clint		· .			eorge's	
Funeral Director		5. Social Security Number	6. Sex 1 ☐ M 2 ☐ F XX	7. Age ( <i>In yr</i> s. 77	Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da)	v. Year)		place (State or Foreign htry) hington DC	
K		578 40 7963 Usual Residence of Decedent	ΛΛ	11				JUCE 10,	1727			
ryland		10a. State 10b. County		10c. Ci	ty, Town or Lo	ocation				1	10d. Inside City Limits	
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nd 2 alth a 27 is		Carol Biggs (	Daughter)		1290	04 Blackw	ater Pla	ce, Clir	ton, N	D 207	35	
298 1 a		20a. Method of Disposition 1 M Burial 2 □ Cremation	2 CRomovel from	I .	Place of Dispo cemetery, crei	osition (Name of matory or other place	ce)	Date	20c. Location	on - City or T	own, State	
Page Tient ant: If		4 Donation 5 Other (S			dar Hi	11 Comete	ry Oct 5	2007	Curi+1	and l	WD.	
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atter for u	ian/Me	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live	utcome of pregrebinth 2 Fet gnant at time of	al death 3[	Ectopic pregnancy Other (specify)	1		23d.	Month	ory Day Year	
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he Hos in 24 hc he Fun pletely	edicai	(Check only 2 Nedical one)	exeminer: On the and ma	basis of examination of the states.	nation and/or in	nvestigation, in my	ppinion, death occi	urred at the time,	date and pla	and place, and due to the cause(s)		
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			State of Maryland / Department of Health and I							0007 0001				
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	Funeral Director		5. Social Security Number 6. Se 262 36 4523	X 7. Age	(In yrs. last b	virthday) Yrs.	If Under 1 Ye Months Day		8. Date of B (Month, I DEC • 9	irth Pay, Year) , 1926	;   SO	thplace (State or Foreign		
	and w		Usual Residence of Decedent  10a. State 10b. County		10c. City, To	wn or Lo	cation					10d. Inside City Limits		
	Maryl I-f sho fled at	tor	MD. N/A		В	ALT]	IMORE					X <sub>1 Yes 2 No</sub>		
36	h with the	Funeral Director	10e. Street and Number 1806 AIKEN STRI	EET			10f. Zip Cod 212			10g. Citize	en of What Co $\Lambda$	ountry?		
	iges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at		11. Marital Status  1 □ Never Married 2 □ Married  3 □ Widowed 4 □ Divorced	12. Was Decedent Ev Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:			Was Decedent of the Ves, specify C	of Hispanic Origin? (Scuban, Mexican, Puerl No <i>Specify</i> :	pecify Yes or No Rican, etc.)		4. Race - Ame Black, Whi	te, etc.		
2	72 ho 'natur	eted	15. Decedent's Edu (Specify only highest grad	ucation de completed)	16	(Give	dent's Usual Oc kind of work do	ne during most of wor	rking	16b. Kind	d of Business	/Industry		
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ylar	l 2 should be filed v h and Mental Hygie r is marked other t raumatic event, th	To B	PAUL WATTS					ELMA	KELLY					
Maryland	d 2 sh th and 7 is m traum		19a. Informant's Name/Relationship (T)					eet and Number or Ro				Zip Code)		
ē,	ss 1 and 2 of Health a item 27 is other trau		PAUL PRESTON ( § 20a. Method of Disposition				sition (Name of matory or other		Date P	_	ation - City or	Town, State		
<u>=</u>	Page ment c ant: If ury or		1 XBurial 2 □ Cremation 3 □ I 4 □ Donation 5 □ Other (Specify,					1	11,200	7 Ba	ltimo:	re, MD		
Baltimore,	permit. Pages 1 an Department of Heal Important: If item 2 any Injury or other once.		4 Donation 5 Other (Specify)   KingMemorialPark Oct.11,2007 Baltimore, MD  21. Signature of Funeral Sarvice Licensee   CALVIN B. SCRUGGS FUNERAL HOME											
			1412 F. PRESTON ST. BALTO, MD. 21213  23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  Approximate											
	Physician		shock, or heart failure. List only one cause on each line.  Immediate Cause (Final FINEUMONIA disease or condition									Interval Between Obset and Death		
)	/Medical Examiner	Examiner	resulting in death)	SEPSIS	e of):									
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3876	icate be o	dical	•	d										
P.O. Box 687	Attending Physician: The law requires that the death certificate be executed r death.  ector: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit	d by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 1% months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		Ectopic pregnancy Other (specify)			23d. Date of delivery Month Day Year						
rds, P	w requires that the de been signed by the s should be detached		Part II. Other significant conditions co	ontributing to death but	not resulting	in the u	nderlying cause	given in Part I.		[	1	o the cause of death? robably 4  ☐Unknown		
Records,	iician: The law re certificate has bec rector, page 2 sho	Completed				-			24a. Wa au pe 1∐ Yes	topsy rformed?"	prior to death?	utopsy findings available completion of cause of		
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O.	Physi rthis c ral dire	은	1 ☐ Yes 2 No 27. Manner of Death						Home 5 ☐ Residence 6 ☐ Other (Specify)					
ion	nding ath. r: Afte e fune	ation	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day	28a. Date of Injury (Month, Day Year)   28b. Time of   28c. Injury at   Work?   1			28d. Describe how injury occurred						
Division or Vital	al or Atte after des Directo d in by th	Certification:	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Num City or Town, State)			Bural Route Number,		
	To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Medical C	29a. Certifier (Check only one) 1 Certifying Phy 2 Medical Exam	yslcian: To the best of niner: On the basis of a and manner state	examination :	ge, deat and/or in	th occurred at th	e time, date and plac ny opinion, death occ	e, and due to the urred at the time	ne cause(s) a e, date and	and manner a place, and du	s stated. le to the cause(s)		
	To the within To the comp	Me	29b. Signature and title certifier	and title certifier  29c. License number  H0063138						29d. Date signed (Month, Day, Year)				
			· ognings			\				(	>/4/	1107		
_	5		30. Name and address of person who of JEFFREY SWETT,		01 05	SLEF	DRIVE	TOWSON	I, MARY	LAND	21204	·		
	Sta Registi		31. Date filed (Month, Day, Year)	39. Registrar	's Signature	ba	will .							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** October 0 2007 5:00 Dorothy Mary /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Genesis Eldercare Hammonds Lane Baltimore Anne Arundel If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 M 2 1 F 218-03-0041 93 June 4, 1914 **Director** Maryland Maryland Usual Residence of Decedent 10c. City, Town or Location 10a. State Md. 10d. Inside City Limits 10b. County 28a-f show items 23a or 28a-f shov ner must be notifled at Anne Arundel 1 ☐ Yes 2 PNo Glen Burnie Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. 21061 110 Forestdale Avenue by Funeral Pages 1 and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Black, White, etc. r than "natural", or iten the Medical Examiner 1 Never Married 2 Married 1 ☐ Yes 2 12 No White 3 NWidowed 4 □ Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Mental Hygiene. Homemaker 10 7 is marked other traumatic event, t 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname Be С. Doetzer Loretta Witte ပ J. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Health and Item 27 i Elizabeth Parks, daughter in law 435 Gatewood Ct. Glen Burnie, Md. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If Ite
any Injury or oth 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Holy Cross Cemetery 10/11/07 Baltimore, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gonce Funeral Service P.A. 4001 Ritchie Hgwy. Baltimore, Md. 21225 namiroli 22a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Find Physician resulting in death) /Medical Due to (or a consequence of): Examiner sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of): physician ar Physician/Medical SE IF FFMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 5 Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown been s 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a. Was an has e 2 autopsy performed? Yes 2 No certificate has rector, page 2 director, To Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 | Inpatient Other: 1 ☐ Yes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA 4X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural (Month, Day Year) Injury

or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, within 24 hours after death

To the Funeral Director:
completely filled in by the f Hospital the

Baltimore, Maryland 21215-0036

State Registrar

5 ☐ Pending investigation 

3 ☐ Suicide 4 Homicide

29a. Certifier

(Check only one)

29b. Signature and title of certifier

Medical

6 Could not be determined

1 ☐ Yes 2 ☐ No

D17743

Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

0

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD 3001 SEENIVASAN

31. Date filed (Month, Day, Year) 9 2007 0

S. HANOVER St, PALTO, 32. Registrar's Signature

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 7, 2007 6:47AM October 0 Nora Marie Panzer /Medical 4c. County of Death 4h. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Silver Spring 1525 Red Oak Drive If Under 1 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex Age (In vrs. last birthday **Funeral** Hours Min Months Days 1 □ M 2 🕅 F New York 149-16-2151 June 28, 1929 78 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene.
Hyer than "natural", or tiems 23a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County "natural", or items 23a or 28a-f show edical Examiner must be notified at 1 ☐ Yes 2 No Director Silver Spring Maryland Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number United States 20910 1525 Red Oak Drive Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married 1 ☐ Yes 2 🛛 No Specify: Specify: ģ 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) the Medical (Give kind of work done during most of working life. DO NOT use retired) Smithsonian College (1-4or 5+) Elementary/Secondary (0-12) Curator of Education American Art Museum 4 permit. Pages 1 and 2 should be filed i Department of Health and Mental Hygic Important: If item 27 is marked other 1 any injury or other traumatic event, th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Bridget McGlynn Thomas McGrath 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type. Print) 1525 Red Oak Drive, Silver Spring, Maryland 20910 Frederick Panzer/ Husband 20b. Place of Disposition (Name of cemetary, crematory or other place)
Montgomery
Crematorium Inc. Date 20c. Location - City or Town, State 20a. Method of Disposition October 2007 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Bethesda, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase. Inc. 755/Wisconsin Avenue Bethesda, Maryland 20814-3501 21. Signature of Funeral Service Licensee M00335 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Myocardial Infarction Physician /Medical Due to (or as a consequence of): Examiner Severe Chronic Obstructive Pulmonary Disease Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine signed by the attending physician and d be detached for use as the burial-transit Chronic Bronchitis Due to (or as a consequence of) Physician/Medical **Emphysema** IF FEMALE: 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death
4 □ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectonic pregnancy Month in the past 12 months? 1 ☐ Yes 2 💆 No 5 Other (specify) 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 9 1 Tyes 2 No 3 Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an cate has t page 2 s autopsy performe 1□ Yes 2X No within 24 hours after death.

To the Funeral Director: After this certifical completely filled in by the funeral director, 26. Place of Death | Check only one) Be 25. Was case referred to medical examiner? Other: 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify) Hospital: 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 1X Yes 2 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 🕅 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident 6 Could not be determined Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3∏ Suicide 4 Homicide 🛣 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number

Division or Vital Records, P.O. Box 68760 To the Hospital or Attending Physician:

Baltimore, Maryland 21215-0036

State

Registrar

31. Date filed (Month, Day, Year) OCT 0 9 2007

of Artifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and titl

Irving Mizus, M.D. 10605 Concord Street #500, Kensington, Maryland 20895 32. Registrar's Signature

D26571

October 8, 2007

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 - For State Registrar	State of IV	laryland / Dep <i>Ce</i>	artment of I		, ,	lene eg. No. $20$	07	3225	52	
	Physicia	an	Decedent's Name (First, Midd					2. Date of Deat Month	Day	Year	3. Time of Dea		
	/Medic	cal	Barbara E. P.  4a. Facility Name (If not institution		A	4h Cih Taur	or Location of Death	Septemb			3.26	₽м_	
	Examin	ıer	Washington Co			Hagers			4c. County of Death  Washington				
نىقد م	Funeral		5. Social Security Number		ge (In yrs. last birthday	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth		ace (State or Fo	reign		
4	Director		214-32-4795	1□M 2√∏ F	74 Yrs.	Months Days	Hours Min.	June 6,	8. Date of Birth (Month, Day, Year) June 6, 1933 Mary				
Maryland a-f show fled at	ctor	Usual Residence of Decedent  10a. State 10b. Count  MD Was	y hington	10c. City, Town or L					10	od. Inside City Li			
	ges 1 and 2 should be filed within 72 hours after death with the Maryland ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene.  The ZT is marked other than "natural" or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	Director	10e. Street and Number			10f. Zip Code		10	0g. Citizen of W		ry?		
		ra	19820 Bennie	Drive			21742		US	A			
0000		by Funeral	11. Marital Status 1 □ Never Married 2 □ Ma 3 ᅑ Widowed 4 □ Divorce	If Yes, Give	No	Was Decedent of If Yes, specify Cub 1 ☐ Yes 2 No	Hispanic Origin? (Spoan, Mexican, Puerton Specify:	pecify Yes or No- o Rican, etc.)	Black	e - America k, White, e whi	etc.		
ה ה	72 hc 'natur dicai	eted	15. Decede (Specify only high	ent's Education est grade completed)	16a. Dece	edent's Usual Occu	pation during most of worked)	king	16b. Kind of Bu	siness/Ind	ustry		
7	vithin ane. Ihan "	Completed	Elementary/Secondary (0-12)		5+)				h o o 1 + h				
7	filed v Hygie ther t		17. Father's Name (First, Middle		re	gistered		ne (First, Middle, M	health Maiden Surnam				
<u></u>	d be ental ked o	To Be	Lawrence Corn		ige		Ella El	lizabeth	Koge1sc	hatz			
2	should I and Men s marke umatic o	F	19a. Informant's Name/Relation	nship (Type. Print)	19b. Mail	ing Address (Stree		dural Route Number, City or Town, State, Zip Code)					
Ž	and 2 ealth a n 27 is er trau		Washington Cou	unty Hospital	L 215	E Antie	tam Stree	t Hagerst	town, MI	217	40		
Dailliore	permit. Pages 1 an Department of Heat Important: If item 2 any injury or other		20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation  4 ☑ Donation 5 ☐ Other (	Specify)	20b. Place of Disp cemetery, cre	osition (Name of ematory or other pla	ace)	Date ;	20c. Location -	City or Tov	vn, State		
	permit. Departi Importi any inji		21. Sign rture of Funeral S, ryice	e Licensee S. Wade, Dir			ess of Facility Comy Board MD 2120		Baltimo	ore S	treet		
	Physician /Medical Examiner		23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure/List only one cause on each line.  Approximate Interval Between Onset and Death disease or condition resulting in death)  Due to (or as a consequence of):  Sequentially list conditions										
In 15 of the Hospital or Attending Physician: The law requires that the death certificate be executed in thin 24 hours after death. The law requires that the death certificate be executed in thin 24 hours after death. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit.	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	· AMIA	s a consequence of):  FIBRIL s a consequence of):	•	Lay 1							
_	ertifica ing ph e as th	Med	IF FEMALE:										
.O. DOX	w requires that the death certif been signed by the attending should be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown		2 ☐ Fetal death 3	□Ectopic pregnanc □ Other <i>(specify)</i> _	су		23d. Date Mor	e of deliver oth	ry Day Year		
COLUS, L	equires that en signed b ould be deta		Part II. Other significant condit	tions contributing to death	but not resulting in the	underlying cause gi	ven in Part I.	23e. Did tob			e cause of death ably 4 □Unkn		
משנו ומ	i: The law r icate has be r, page 2 shi	Completed by						24a. Was ai autops perforn 1∐ Yes 2	y p	rior to con leath?	osy findings avai apletion of cause 2 No	lable e of	
<u> </u>	siciar certif rector	Be	25. Was case referred to medic examiner?			Ot	hor:	th (Check only on					
5	J Physer this eral di	: To	1 Yes 2 No 27. Manner of Death	28a. Date of Inj	jury 28b. Time	III 3 DOA	4 Li Nursing H	ome 5 Reside		, , , , ,	)		
5	ath. r: Afte e fun	ation	1 Natural 5 Pendi 2 Accident invest	ing (Month, Di tigation	ay Year) Injury		ork? ]Yes 2 □No						
To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 to	Certification:	3 Suicide 6 Could 4 Homicide determ		28f. Location (Street and Number or Rural Route Number City or Town, State)									
	n 24 hour n 24 hour ne Funera	Medical (	29a. Certifier 1 Certify (Check only one) 1 Medica	ing Physician: To the bes al Examiner: On the basis and manner s	of examination and/or i	th occurred at the t	time, date and place opinion, death occu	, and due to the ca irred at the time, d	ause(s) and ma ate and place, a	nner as stand due to	ated. the cause(s)		
	To the complete compl	Z	29b. Signature and title of certific				se number		29d. Date signed (Month, Day, Year)				
				mn	·	DU	1622	6:	Shug Lang	RSO.	2007	-	
			30. Name and address of person	am ma	death (Item 23a) (Type	, Print) IBBNIWU	1602 110WDR,	ACREST	oun,	MD E	1742		
	Sta Registr		31. Date filed (Month, Day, Year OCT 0		trar's Signature	boule							

DHMH 17 Rev 1/2001

DHMH 17 Rev 1/2001

Registrar

07-07715 Calvin Ray Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2007 32254

	1- For State Registrar	(	Certificate of	Death		Reg.	. No	
Physician/	Decedent's Name (First, Mide					2. Date of Death Month	Day Year	3. Time of Death 2357 hrs
Medical Examiner	CALVIN  4a. Facility Name (if not instituti	RAY_JR.		4b. City, Town, or L	ocation of Dea	October 2, 2	4c. County of Deat	
	300 East Madison St			Baltimore				
Funeral	5. Social Security Number	6. Sex 7. Age (In y	rs. last birthday)	If Under 1 Year Months Days	If Under 24H Hours M	_	(MM/DD/YYYY) 9. Bi Forei	rthplace (State or gn
Director	220-11-2691	1 <b>X</b> M 2 F 21	Yrs		Tiodis	12-04-		ountry) MD
á	Usual Residence of Decedent  10a. State 10b. County	/ 10c.	City, Town or Locat					10d. Inside City Limits
daryland 28a-f show any 1 at once.	MD		BALTIMOR	Œ				1 Yes 2 No
the Maryland a or 28a-f shu iffied at once	10e. Street and Number 420 CUMMINGS	CT.		10f. Zip Code 21201		10g	. Citizen of What Cou	untry?
th the 23a or notifie			:- II		nanic Origin? (	Specify Yes or No-	USA	rican Indian, Black,
or items 23	11. Marital Status  1 X Never Married 2	Married 12. Was Decedent Ever Armed Forces? 1 Yes 2 X	If Y	es, specify Cuban			White, etc.	
ifter de	3 Widowed 4 II	1 Yes 2 X I	1	Yes 2 No	specify:		Specify: BLA	CK
nours aft natural Examine	15. Decedent's Education (Sp	ecify only highest grade complete		nt's Usual Occupati nost of working life.			16b. Kind of Business	/Industry
36 in 72 than " dical I	Elementary/Secondary (0-12	2) College (1-4 or 5+)	PACKEI	3			BAKERY	
21215-0036 alid be filed within 72 hours after death with the Maryland Mental Hygiene. marked other than "natural", or items 23a or 28a-f she event, the Medical Examiner must be notified at once for Be Completed by Funeral Director	17. Father's Name (First, Middl					me (First, Middle, Ma		
1215 1 be fill ental H arked vent, t	CALVIN M. RAY,		40h Mallin	a Address (Chase		ADETTE GO	per, City or Town, Star	ta. Zin Coda)
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.  To Be Completed by Funeral Director	19a. Informant's Name/Relation BETTIE SEA/GRA	NDMOTHER				, BALTO.,		le, Zip Code)
e, M I and 2 Health item 2	20a. Method of Disposition		20b. Place of Dispos crematory or of	sition (Name of cer			20c. Location - City of	or Town, State
MOF Pages ent of unt: If	1 X Burial 2 Cremati 4 Donation 5 Other	on 3 Removal from State	WESTERN (	CEMETERY		0-10-2007		
Baltimore, permit. Pages I an Department of He Important: If ite	21. S. nature of Funeral Service							NS F.H., INC
	23 Part I Enter the disease.	or complications that caused the c				, BATLO.,		Approximate Interval
Physician /Medical	failure. List only one caus	se on each line.						Between Onset and Death
.xaminer	Immediate Cause (Final disea or condition resulting in death)		nce of):					
100	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a conseque	nce of):					
ية السبب	cause. Enter Underlying Caus (Disease or injury that initiated	C	neo of):					
Example 1	events resulting in death) Las	d.						
760, icate be executed physician and the burial - transit	UNPENDED	X AMENDED #1, 2	392 <sup>27</sup> 18/976	ppr/E#875	eme/,68/9	8 TT/9/07 T	Γ	
760 ficate b g physi the bu		23c. If yes, outcome of	pregnancy		Ectopic pre		23d. Date of deliver	ery Day Year
Box 68's death certification of the attending ed for use as the street of the street o	past 12 months?	Pregnant at time	f 1 - 1	other (Specify)				
). Box 687 the death certific by the attending Inched for use as the	Part II. Other significant con	3 GIRIOWII	not resulting in the	underlying cause	given in Part I	23e. Did to	bacco use contribute	to the cause of death?
by detz	5	dictions contributing to death but	, not resulting in the	dilucitying dudge	givoniii airi			robably 4 🗹 Unknown
ds, require could be						24a. Was a		autopsy findings available o completion of cause of
of Vital Records, I ge Physician: The law requires the trulis certificate has been signeral director, page 2 should be not To Be Completed		<u>.</u>				perfor	med? death	?
ن ا≊ق ط ۲۵				26.Place	e of Death (Che			
FVita Physician this control of To B	1 🗸 Yes 2 No	Hospital: 1 Inpatient					Residence 6 V Oth	her: Scene
_ = < .> =	27. Manner of Death  1 Natural 5 Pe	28a. Date of Injury (Month, Day, Year)	28b. Time of	1	uryat Work? Yes 2 Ⅹ No		nanged self	
Division tal or Attendi rs after death. at Director: /	2 Accident In	vestigation FNd 10/2/200		29 pm L _		28f. Location (S	Street and Number or	Rural Route Number, City
Division of National of Attending Phonus agreed earth and the function. After filled in by the funcial Certification. T	3 X Suicide 6 C	ould not be	in Correct			or Town, S 300 E. Ma	<sup>tate)</sup> adisən St. B	altimore. MD
2 5 5 5		Physician: To the best of my knox aminer:On the basis of examine	owledge, death occ	urred at the time, d	late and place,	and due to the caus	e(s) and manner as s	tated.
To the Hos within 24 h To the Fun completely	one) 2 Medical E	and manner stated.			se number	od de tilo tillo, dato	29d. Date signed (i	
A A	290. Signature and title of cer	11 11:			.M.E.	OCME	October 3, 200	
1 July of the	3 Name and address of pers	son who completed cause of death	(Item 23a)					
14	Theodore M. King,			111 Penn S	treet, Baltim	nore, MD 21201	l	
Stat Registra	111' (	ar) 9 2007 32. Registrar's S	Signature	rester				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** October 4, 11: YOAM Roberts 2007 Shirley Ann /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Co. Edgemere 4 Strebor Road Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 6. Sex 5. Social Security Number **Funeral** Days Months Hours 1 □ M 2 X F 67 June 17,1940 Maryland 218-36-9219 Director Usual Residence of Decedent 10d Inside City Limits 10c. City, Town or Location 10a. State 10b. County d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 1 TYes 2XXNo Director Edgemere Baltimore Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 21219 4 Strebor Road Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 【XNo If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🔼 No White Specify: 2 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) within 72 12 should be filed within 7 h and Mental Hygiene. 7 **Is marked other than "r** College (1-4or 5+) Elementary/Secondary (0-12) Homemaker 12 Years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mildred Marie Kyle Arthur Frank Gilday Pages 1 and 2 should traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Husband Edgemere, Maryland 21219 4 Strebor Road nt of Health a If item 27 is or other trai Mr. Raymond Charles Roberts 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition permit. Pages Department of I Important: If its any Injury or o' 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore, Maryland Oak Lawn Cemetery 10/6/2007 5 Other (Specify) 4 □ Donation 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, 21. Signature of Juneral Service Licenses Dundalk, Maryland 21222 7922 Wise Ave. 23a. Part1. Enter the discase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fallore. List only one cause on each line. Immediate Cause (Final myo cardin **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine sician and burial-trans Due to (or as a consequence of): physician sthe burial Physician/Medical attending pl for use as t IF FEMALE 23d. Date of delivery 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ 1 ☐ Live birth 2 Fetal death Month Day in the past 12 months? 4☐Pregnant at time of death I□Yes 2□No signed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autoosy performed? Hospertenseon 20 1□ Yes 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ၉ this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: After 1 Injury 1 Naturai 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be determined Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 Homicide

or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

Maryland 21215-0036

altimore,

10 Registrar

Medical

RONNO ATTANASIO

29b. Signature and title of certifier

29a. Certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ROWMD ATTANNSio, MD 9114 Philadelphia Rd., Suite 108; Balt.; Hd 21237.

attorraser

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

0-28097

29d. Date signed (Month, Day, Year)

			For State Registrar	State of Marylan		rtment of I		Mental Hyg	iene <sub>eg. No</sub> 2007	32256
П	Diam'r.		Decedent's Name (First, Middle, Last	)				2. Date of Deat	h	3. Time of Death
П	Physicia /Medic			imrodt					·	
	Examin		4a. Facility Name (If not institution, give				or Location of Deat	on	4c. County of Dea	
h	Funeral Director		5. Social Security Number 6. Se 548-53-0766	7. Age ( <i>In yrs. I</i> YM 2□F 41	as <i>t birthday)</i> Yrs.	If Under 1 Year Months Days	Hours Min.			thplace (State or Foreign puntry) ifornia
V			Usual Residence of Decedent							
	arylan show d at	۲	MD Baltimor		, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	the M 28a-f notifie	ecto	10e. Street and Number			10f. Zip Code		1	Og. Citizen of What Co	ountry?
	3a or		8932 Satyr Hill Ro			21234			USA	
	death	Funeral Director	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?	S. 13. \	Vas Decedent of Yes, specify Cul	Hispanic Origin? (S	Specify Yes or No- rto Rican, etc.)	14. Race - Ame Black, Whi	
36	be filed within 72 hours after death with the Maryland Ital Hygiene. d other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ∐ Yes 2 <b>XX</b> No If Yes, Give Year or Dates:		I□Yes <b>XX</b> No			Specify:	White
Ö	2 hour	ed b	15. Decedent's Ed	ucation	16a. Deced	ient's Usual Occu	pation	1	16b. Kind of Business	/Industry
215	thin 7% e. an "na Media	Completed	(Specify only highest grad	Gollege (1-4or 5+)			during most of wo ed) nsultant	prking	Governmen	+
2	led wil	Con		13 +	LOTT	CICAL CO		me (First, Middle, I		
Maryland 21215-0036	d be file	Be	17. Father's Name (First, Middle, Last)  Gary Lee Rimrodt				1	A. Sayat		
ary	should be fand Mental I	ဥ	19a. Informant's Name/Relationship (7	ype. Print)					, City or Town, State,	Zip Code)
Ž,	and 2 ealth a n 27 ls		Sheryl Lynn Rimro			<del>-</del>	ill Rd. B		, MD 21234	7
altimore,	permit. Pages 1 and 2 should be for Department of Health and Mental I Important: If item 27 is marked of any injury or other traumatic ever once.		20a. Method of Disposition  XXBurial 2 □ Cremation 3 □  4 □ Donation 5 □ Other (Specify	Removal from State	emetery, crer	sition (Name of matory or other pla Cemeter	y 10/		20c. Location - City or altimore,	
Balt	permit. Departr Importa any inja once.		21. Signature of Funeral Service Licen			Name and Addr	ess of Facility on Funera	Towson, M al Home,	aryland 21 Inc. 1050	204 York Road
Н			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	one cause on each line.					est,	Approximate Interval Between
	Physician	9	Immediate Cause (Final disease or condition resulting in death)	.a. METASTATIO				IFORME		Onset and Death
	/Medical Examiner		Tooling in dealing	Due to (or as a conseq INTRACEBRE	uence of): AL HEI	MORRAGE				WEEK
j.		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a conseq	,					
/	scuted nd transit	Examiner	that initiated events	. ASPIRATION		AINOML				WEEK
,094	ate be executed hysician and the burial-transit	al Ex	resulting in death) Last	Due to (or as a conseq	uence of):					
687	ficate physi s the I	edical		d						
Box	The law requires that the death certificate be executed tte has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome pf pregna	I death 3	∃Ectopic pregnan	су		23d. Date of de Month	elivery Day Year
о. Ш	he dea the at	ysici	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4⊡Pregnant at time of d 9⊡Unknown	leath 5	Other (specify)				
α_	w requires that the debeen signed by the should be detached		Part II. Other significant conditions of	ontributing to death but not res	uiting in the u	nderlying cause g	iven in Part I.	23e. Did to	bacco use contribute	to the cause of death?
rds	equires en sign	ed by						. 1□Y	es 2∭XNo 3∏F	Probably 4 Unknown
Records,	e law re has bee	Completed						24a. Was a	24b. Were a	autopsy findings available completion of cause of
		Con						perfor 1☐ Yes	med? death? 2.No 1 □ Ye	s 2 No
Viita	sician: Th certificate irector, pag	Be C	25. Was case referred to medical examiner?  1 Yes 2 No	Hospital: 1 npatient 2	ER/Outpatier	* 3000A	thor	eath (Check only or	ne) ence 6 □Other (Sp	onificial and the second
ō	ding Physician: The n. After this certificate his funeral director, page	n: To	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time o				ow injury occurred	өсну)
Sion	Attending Physician: or death. ector: After this certifically the funeral director, I	atio	1 Natural 5 Pending 2 Accident investigation			M 1[	∏Yes 2 ☐ No			
Division or	r te te	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At he building, etc. (Special	ome, farm, sti fy)	eet, factory, office	Э	28f. Location (S City or Tow	treet and Number or F n, State)	Rural Route Number,
_	To the Hospital or Attena within 24 hours after death To the Funeral Director: completely filled in by the	Medical Ce		ysician: To the best of my kno niner: On the basis of examina and manner stated.						
	To the To the To the Comple	Me	29b. Signature and title of certifier	Allele	1		nse number	4	29d. Date signed (Mor	nth, Day, Year)
			10	- Cecere		DØØ	157288		10/8/0	) <del>/</del>
	1		30. Name and address of person who	completed cause of death (Iter			OWSON.	MARYLAN	D 21204	
	Sta	ate	31. Date filed (Month, Day, Year)	32 Registrar's Signa						
	Regist		OCT 0 9 20	107 Bleen &	1 As	will				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 10:30 AM Dorothy Higson Reel 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** osedale Baltimore HOSpital 8. Date of Birth

Jan. 5, 1922 If Under 24 Hrs. If Under 1 Year 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday **Funeral** Days Months Virginia 1 □ M 2 💢 F 85 225-16-7175 **Director** Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County ortant: If Item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 1 TYYes 2 □ No Director Virginia Beach N/AVirginia 10g. Citizen of What Country? 10e. Street and Number 23464 United States 3129 Manatee Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: White Specify: þ 3 Widowed 4 □ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any injury or other trainment. Elementary/Secondary (0-12) College (1-4or 5+) Cork Manufacturing Cutter 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lockyer Edward Higson Lily ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1117 Windy Branch Way Edgewood, Maryland 21040 Dorothy R. Humphries Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Norfolk, Virginia Riverside Mem. Park 10-11-07 4 ☐ Donation 5 ☐ Other (Specify) of Funeral Service Libensee 22. Name and Address of Facility Mitchell-Wiedefeld F.H. Inc. 21. Sign CUU/OI 6500 York Road Baltimore, Maryland 21212 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications shock, or heart failure. List only one cause on caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final **Physician** Stau disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that in its lead as each of the conditions of th Due to (or as a consequence of): Examiner sician and burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Division or Vital Records, P.O. Box 68760, Due to (or as a consequence of): been signed by the attending physician should be detached for use as the buria by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 ☐ Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 9☐Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 □ Yes 2 □ No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an after death.

Director: After this certificate has I in by the funeral director, page 2 s autopsy performe rmedZ 2 ☑ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manher of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide determined To the Hospital within 24 hours at To the Funeral C 29a. Certifier 1 💆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year) **OCT 0 9** 2007

3. Registrar's Signature

quare Drive

-2007

Balto. MD

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** SALTER Da 2007 7 /Medical 4a. Facility Name (If not institution, give street and number City, Town, or Location of Death County of Death Examiner CENTER If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, Year) June 17,1924 9. Birthplace (State or F Country) Maryland 9. Birthplace (State or Foreign Security Number **Funeral** Min. Days 1 □ M **X** X F Hours 83 Director 217-12-6264 Usual Residence of Decedent 10c. City, Town or Location la or 28a-f show t be notified at 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 🏋 🎖 No Director MD **Baltimore** Owings Mills the 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? ms 23a c 9725 Lyons Mill Rd. 21117 U.S.A. permit. Pages 1 and 2 should be filed within 72 hours after death Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23 any Injury or other traumatic event, the Medical Examiner must Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 文質 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specity Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married XXMarried 1 □ Yes XX No Baltimore, Maryland 21215-0036 Completed by White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Heson, Westcott & College (1-4or 5+) Elementary/Secondary (0-12) Lab Technician Dunning 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ျှ John F. Sapp Agnes Adams 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9725 Lyons Mill Rd. Owings Mills, MD 21117 Thomas W. Hardy / Friend 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Druid Ridge Cemetery XXBurial 2 Cremation 3 Removal from State 4 Donation 5 Dother (Specify) 10/10/07 Pikesville, MD 21. Signature of Funct V Service Licer 22. Name and Address of Facility Eckhardt Funeral Chapel P.A. 11605 Reisterstown Rd. Owings Mills, MD21117 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immer late Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed physician and the burial-transi Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical attending ph for use as th IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 4-Unknown 1 ☐ Yes 2 1 No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an has certificate ha autopsy performe 1□ Yes 2 3/10 To the Hospital or Attending Physician: After this certification, I 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 11 Inpatient Medical Certification: To 2 ER/Outpatient 3 DOA 27. Mannet of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural (Month, Day Year) Injury 5 Pending 1 ☐ Yes 2 ☐ No s after death. I Director: A od in by the fu investigation 2 Accident 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours aff To the Funeral D completely filled in 🛮 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Registrar

31. Date filed (Month, Day, Year) OCT 0 9 2007

tle of certifier

SHWAF

39. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and

29c. License number

CTR.

29d. Date signed (Month, Day, Year)

2007

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** SHIELDS between BEVERLY 200 /Medical 4b. City, Town, or Location of Death 4c. County of De 4a. Facility Name (If not institution, give street and number) Examiner CEN TON Ventorwell KANDALLSTENA If Under 24 Hrs. Hours Min. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Year Months 1 □ M 2 🔽 F 53 05 Director 12 MI 386-62-5908 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show X□Yes 2□No iral", or items 23a or 28a-f sh Examiner must be notified Director Baltimore MD NA 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21217 U.S.A. 6700 Wilmount Drive Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 72 hours after 1 Yes Y No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No þ Specify: Black 3 ☐ Widowed 4 ☐ Divorced "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation other traumatic event, the Medical (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Private Health Care Provider 12th grade 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Mental Hy Important: If item 27 is marked othrany injury or other traumatic event once. 17. Father's Name (First, Middle, Last) þ Elmore Boxton Ernest Friday 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert L. Sheild-Husband 6700 Wilmount Drive, Baltimore, 21207 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Garrison Forest Vet 10/10/07 Owings Mills, Md 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
March F/H West Funeral Service Licen 4300 Wabash Ave, Baltimore, Md 21215 23a. P. 11. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, lock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Imm diate Cause (Final dist ase or condition sulting in death) SEPSIS Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examiner executed burial-transit Cause (Disease or inju-that initiated events resulting in death) Last and Due to (or as a consequence of): Box 68760. attending physician pe Physician/Medical for use as the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Year 4☐Pregnant at time of death 5 Other (specify) i signed by the a ld be detached f P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, à ENDSTACE RENAL DISTASE ! NOW Small CELL CARRENEM 3 Probably 1 ☐ Yes 2 ☐ No 4 ☐Unknown funeral director, page 2 should Completed been of hine; Diapetic mollitus conowany 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ NO performe atrinia ATRIAL FOBRICATION. certificate l Costructive have Disense 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 1 Impatient 2 ER/Outpatient 3 DOA Certification: To this 27. Mann of Death 1 Matural 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After t To the Hospital or Attending I within 24 hours after death.
To the Funeral Director: After 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ACSPITAL B. CONKNAN ONLANDO 32. Registrar's Signature 31. Date filed (Month, Day, Year) State BARL! OCT 0 9 2007 Registrar

DHMH 17 Rev 1/2001

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

**Funeral** 

Director

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Director

Funeral

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permit. Pages 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or items 23a or 2 and 1 injury or other traumatic event, the Medical Examiner must herefore.

Baltimore, Maryland 21215-0036

Examiner pue the burial-tra attending physician for use as the buria Physician/Medical ed by the detached page 2 should be de þ Completed certificate within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, Be 7 Certification:

Medical

one)

29b. Signature and the of certifier

The law requires that the death certificate be executed

or Attending Physician:

To the Hospitai

Division or Vital Records, P.O. Box 68760,

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 23b. Was decedent pregnant in the past 12 months? ☐Yes 2☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. Was an autopsy 2 No Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 ☑ Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

VITAL INSCI MS. 5601 LOLL RAYLE BITC. (GOOD SARARITAN HOSPITAL 31. Date filed (Month, Day, Year OCT 0 9 Year) 32. Registrar's Signature

and manner stated.

The Coppens

marke

29c. License number

NPI-1871561043

29d. Date signed (Month, Day, Year)

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) October 5, 200<sup>7</sup>7<sup>ai</sup> 1:40 Elizabeth Sellman Helen 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Baltimore Greater Baltimore Medical Center Towson 8. Date of Birth (Month, Day 15, Birthplace (State or Foreign Country) Maryland If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) Days Hours 65 212-40-5231 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limite 10b. County 1 ☐ Yes 2 No Cockeysville Baltimore Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number United Of States Of America 21030 326 CranBrook Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces Black, White, etc. 1 ☐ Yes 2☐ If Yes, Give Year or Dates: 1 Never Married Married No 1 ☐ Yes Specify. Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Relizon Mail Clerk N/A 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Vernie Minnick Helen Avres 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 326 CranBrook RD. Cockeysville, Maryland 21030 Sellman- Husband Jack 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Oct.9,2007 Moreland Parkville, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility EVANS FUNERAL CHAPEL & CREMATION SERVICES dichara 8800 Harford Road, Parkville, Maryland, 21234 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) UMOURY Due to (or as a consequence of Sequentially list conditions, in a sequentially list conditions, in a sequential cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Due to (or as a consequence of) IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 3 □Ectopic pregnancy Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Onknown PINATORY FAILURE 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform No No 25. Was case referred to medical examiner? 1 Yes 2 No (Specify) 27. Manner of Death 1 Natural 2 Accident

**Physician** /Medical Examiner

certificate be executed

Box 68760.

Records, P.O.

Division or Vital

**Physician** 

/Medical

Examiner

**Funeral** 

Director

show

r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at

filed within 72 hours after

Hygiene.

permit. Pages 1 and 2 should be filed be propertiment of Health and Mental Hygic Important; If item 27 is marked other any Injury or other traumatic event, If any Injury or other traumatic event, If Item 27 is marked other any Injury or other traumatic event, If Item 27 is marked other traumatic event, If Item 27 is marked other in Item 25 is a second content and Item 25 is a sec

Baltimore, Maryland 21215-0036

Director

Funeral

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Physician/Medical

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Certification:

Medical

3 ☐ Suicide

29a. Certifier

4 ☐ Homicide

burial-tran and ed by the attending physician detached for use as the buria signed by t peen has To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director,

Hospital: 1 Inpatient	2 ER/Outpatient	3□ DOA	Other: 4	☐ Nursing Ho	me 5 Residence	6 Other
28a. Date of Injury (Month, Day Yea	28b. Time of Injury	28c.	Injury at Work?	2 □No	28d. Describe how inj	ury occurre

Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number 29d. Date signed (Month, Day, Year)

23a) (Type, Print)

5 ☐ Pending investigation

determined

32. RegisMar's Signature 31. Date filed (Month, Day,

State Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State of Maryl	-	artment of H rtificate of L		lental Hyg ı	Reg. No. 2	007	32262
E	Division to t	4	1. Decedent's Name (First, Middle,	Last)				2. Date of Dea	ath Day	Year	3. Time of Death
	Physicia /Medic		Grace M	Marie Stot	tlemyer			Octobe	r, 7, 2	007	2:18 A M
	Examin	er	4a. Facility Name (If not institution,			4b. City, Town, or	Location of Death		4c. Cou	nty of Death	
		- 10	220 S. Highland 5. Social Security Number		yrs. last birthday)	Baltin If Under 1 Year	nore If Under 24 Hrs.	8. Date of Birt	h	9 Birthn	lace (State or Foreign
	Funeral Director			1 M 2 F	Yrs.	Months Days	Hours Min.	Month, Da.	y, Year)	Mary]	lace (State or Foreign stry)
ń			216 24 3260 Usual Residence of Decedent	X				INOV ZO	1323	Mary	Lanu
	yland how at		10a. State 10b. County	10c	. City, Town or Lo	cation				1	0d. Inside City Limits
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	iff the or 28	Directo	10e. Street and Number	_		10f. Zip Code	20.4		10g. Citizen	of What Cour	
	be filed within 72 hours after death with the Maryland Hygiene. Hygiene. dother than "natural", or items 23a or 28a-f show dother than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	ral	220 S. Highland		:-110 1403	212		asifu Van ar Na	14	US. Race - Americ	
	er de items ner n	Funeral	11. Marital Status  1 ☐ Never Married 2 ☐ Marrie	12. Was Decedent Ever Armed Forces? d 1 ☐ Yes 2 ☑ No	In U.S. 13.	Was Decedent of H If Yes, specify Cuba	an, Mexican, Puerto	Rican, etc.)	17.1	Black, White,	
36	ırs aft I", or xami	by F	3₺ Widowed 4 Divorced	If Yes, Give Year or Dates:		1⊡Yes 2XX No	Specify:		Spe	ecify: W.	hite
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21	filed within Hygiene. other than "	5	8		Labo	rer				anufac	turing
D D	tal H d oth even	Be	17. Father's Name (First, Middle, L Joseph	<sup>ast)</sup> Brashears			18. Mother's Name	e (First, Middle, Kolb	Maiden Sur	name)	
<u>\frac{2}{3}</u>	should be ind Mental marked o	ဥ			10h Mailin	ng Address (Street			or City or To	wa Stata Zin	Cadal
Maryland	S S S		19a. Informant's Name/Relationsh			Nicholsor					Codey
	s 1 and 2 of Health item 27 i		Janie Conway  20a. Method of Disposition	(daughter)		NECTIOESOI psition (Name of matory or other place		Date Mar		on - City or To	own, State
و	Pages nent of int; If it		1 XBurial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp	3 Hemovai from State				11 200	7 Ral+	imore	County,Md
altimore,	permit. Page Department of Important; If any Injury or once,		21. Signature of Funeral Service L			2. Name and Addre		ruzdzin			
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	*		23a. Partt . Efter the disease, or o	complications that caused he only one cause on each line.	death. Do not ent	ter the mode of dyir	ng, such as cardiac	or respiratory a	rrest,	,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	and the same of th	nous C		ercenon	grantle	Tons	al	Onset and Death  13 mon 1/m
	/Medical		resulting in death)	Due to (or as a cor	nsequence of):			U	0 ra - 000a		
6	Examiner	L	Sequentially list conditions, if any, leading to immediate	b	noen	cell ce	runo	ma o	proor	rarynx	13 months
Т	sit sed	nine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a cor	nsequence or).					Į,	
1	xecul al-trar	Examiner	that initiated events resulting in death) Last	C Due to (or as a cor	nsequence of):						
68760,	The law requires that the death certificate be executed the has been signed by the attending physician and tage 2 should be detached for use as the burial-transit			C <sup>d</sup>							
89	tificatu g phy as the	edical									
ŏ	th cert	N/us	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome pf pr 1 Live birth 2		⊒Ectopic pregnancy	,		23d.	Date of delive	•
P.O. Box	e deal	Physician/M	in the past 12 months? 1 □ Yes 2 No	4⊟Pregnant at time 9⊟Unknown		Other (specify)	,			Month	Day Year
<u>Ч</u>	d by t	Phy	9 ☐ Unknown  Part II. Other significant conditio	ne contributing to death but no	t reculting in the u	inderlying cause giv	on in Part I	23e Did t	obacco use i	contribute to t	he cause of death?
	ires the signer	þ	Part II. Other significant conduct	is contributing to death but no	t resulting in the u	inderlying cause giv	en in r care.	154			babiy 4 □Unknown
Vital Records,	w require been sign should b	Completed						24a. Was			opsy findings available
Rec	has l	d m						auto		prior to co death?	mpletion of cause of
g	n: Th ficate or, pag		25. Was case referred to medical				26. Place of Dea	1 Yes		1 □ Yes	2 No
5	rsicia s certi lirectc	o Be	examiner?  1 □ Yes 2 ▼ No	Hospital: 1 ☐ Inpatient	2 ☐ ER/Outpatier	nt 3 DOA Oth	or.	ome 5 <b>X</b> Resi		Other (Specia	fv)
Division or	g Phy er this eral o	n: To	27. Manner of Death	28a. Date of Injury	28b. Time o			28d. Describe			
<u>o</u>	ath. r: Aft	atio	1 Natural 5 Pending 2 Accident investig	ation	ar) Injury		Yes 2 □ No				
<u>S</u>	r Atte er de irecto	Certification:	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi		At home, farm, str pecify)	reet, factory, office		28f. Location ( City or To	Street and N wn, State)	umber or Run	al Route Number,
	ital o Irs aft ral Di										
	Hosp 24 hou Fune tely fi	Medical		g Physician: To the best of my Examiner: On the basis of exa and manner stated.							
	To the Hospital or Attending Physician: The lwithin 24 hours after death.  To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Mec	29b. Signature and title of certifier			29c. Licens		T	29d. Date s	igned (Month,	Day, Year)
	⊢ ≤ ⊢ ŏ		. Levor	sallam 1	U.D.	D4	2239		10-	08-2	2007
7	.0										
	10		5. SIVASAICA	n. 9114, P	hiladel	lphia &	oad, s	uite 2	08,1	Salten	nose (LL) 2/23"
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's	Signature	backer					
	Regist	all	OCT 0	9 2007 Denense	1 St Att	THE SAME					

DHMH 17 Rev 1/2001

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ORIGINAL

Division or Vital Records, P.O. Box 68760, or Attending Physician: within 24 hours a

funeral Funeral Director: tely filled in by the

2 Accident 3 ☐ Suicide 4 Homicide

29a, Certifier

(Check only

29b. Signature and title of

5 Pending investigation 6 Could not be determined

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number

28f. Location (Street and Number or Rural Route Number, City or Town, State)

21204.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MILTO M.D. 7600 OSLER DR. JOHN SUITE 210 TOWSON, MD.

State Registrar

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For		State	of Mary	land /	-				and M	ental H	ygien	е			
			<ul><li>State Registrar</li></ul>					Cert	tificate	e of E	Death			Reg. N	0.20	07	32	264
	Dhysisis		1. Decedent's Name	e (First, Middle,	Last)								<ol><li>Date of I Month</li></ol>		,	/ear	3. Time-e	if Beath
	Physicia /Medic		RALPH	GABRIE	L STRAI	PPELLI							OCTOB				21:3	35 <sup>™</sup>
	Examine	er	4a. Facility Name (h		-		YICIN 70111: "IT				Location of	of Death			c. County of			
		e con	5. Social Security N		LAKE MED 6. Sex		n yrs. last b		BEL .		If Under	24 Hrs.	8. Date of I	Birth		9. Birthp	ace (State	or Foreign
- 6	Funeral Director		218 <b>-</b> 18 <b>-</b> 58		1 <b>∑X</b> M 2□F		33	Yrs.	Months	Days	Hours	Min.		Day, Yea 26 ,		Coun	rland	
		ŀ	Usual Residence of										ocp.					
	how how	_	10a. State	10b. County		10	c. City, To	wn or Loc	ation							1	0d. Inside 0	Sity Limits
	e Ma 3a-f s	cto	Maryland		:d		Bel A	\ir						140	201			
	or 24	Director	10e. Street and Nur						10f. Zip						Citizen of Wh	iai Couri	uy?	
	hours after death with the Maryland tural", or items 23a or 28a-f show al Examiner must be notified at	Funeral	704 Hes	ton Cou		ecedent Eve	r in U.S	13. W	210		spanic Or	igin? (Spe	cify Yes or		5A 14. Race	- Americ	an Indian,	
d d	ter de	٦	<ol> <li>Marital Status</li> <li>Never Marr</li> </ol>	ied 2 <b>∏</b> Marri	Armed	Forces? s 2 No Give	0.0.	If	Yes, spe	cify Cuba	n, Mexica	n, Puèrto	Rićan, etc.)		Black	White,	etc.	
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135 PM 15-0036	be filed within 72 hours after death with the Marylar utal Hygiene.  d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at event,	Completed	(Spec	15. Decedent	s Education t grade complete	ed)	16	a. Deced	kind of wo	rk done c	lurina mos	at of worki	ng	16b.	Kind of Bus	iness/Ind	lustry	
	within 7 ene. than "i he Med	nple	Elementary/Seco			e (1-4or 5+)		life. D	OO NOT u	se retired	"				a D		Q	
<u>7</u>	led w lygier her th		12 17. Father's Name	(Eirot Middle	agt)			Lette	er Ca	rrie		er's Name	(First, Midd		S. Pos		serv.	<u>rce</u>
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07 $2$ aryland 212	2 should be filed withir and Mental Hygiene. is marked other than aumatic event, the Me	ဍ	19a. Informant's N				19	9b. Mailin	g Address	(Street a					y or Town, S	tate, Zip	Code)	
Z aa	nd 2 s Ilth ar 27 is r trau		Catherin			i / Wi	ife -	704 E	Testo	n Co	urt.	Be1	Air,	MD 2	1014			
, ē	s 1 at f Hea item othe		20a. Method of Dis	position			20h. Place		sition (Nai	ne of	- 7		Date	20c.	Location - C	City or To	wn, State	
OE	Page rent o nt: If iry or			□ Cremation     5 □ Other (S)	3 □Removal fro necify)	om State	Dular	ney V	7alle	y Me	m. [	10-10	-07	Ti	monium	ı, Ma	arylar	nd
$\frac{10}{5}$ Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic evonce.		21. Signature of Fi	uneral Service	icensee			MC	. Name ar	d Addres	ss of Facil nera	Hon	e, P.	Α.				
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	/Medical Examiner		resulting in death)		Due	to (or as a c CUTE to (or as a c VGAE	consequenc	ce of):	de	VAN	(4.5	MNA	14000	26 1	NCARI	timal		
7	Examino.	<u>~</u>	Sequentially list of	onditions,	b. Due	to (or as a c	onsequenc	ce of):	800		2,, 0	11/0	4/1001	//	VINIC.	11010		
7	ited nsit	Examiner	Sequentially list on if any, leading to in cause. Enter Undo Cause (Disease of that initiated event	erlying r injury	SA	URAG	PERC	10140	SAA	LVI	Scen	20	186AS	6 M	THI GA	Was	ENE	
3,	executed n and ial-transit	Еха	resulting in death)	Last	C. Due	to (or as a c	onsequenc	e ut).										
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A ON W. Records, P.O.	w requires that the de been signed by the s should be detached		Part II. Other sign	A pr	ons contributing to	o death but r	not resulting	g in the ur	nderlying	ause giv	en in Part	l.	23e. D	id tobacc	o use contri	bute to t	he cause o	f death?
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جـ ۔	\$ 00	o B	examiner?	No	Hospital: 1	Inpatient	2 🗆 ER/	Outpatien	nt 3 □ D	OA Oth	ier: 4 🗆 N	lursing Ho	me 5□F	Residence	e 6 □Othe	er (Speci	fy)	
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Ŏ.	Attending r death. ector: Afte by the fune	Certification:	1 X Natural 2 ☐ Accident	5 Pendin investi	jation				М		Yes 2	]No						
9	or Atterder de Directeri by t	tific	3 ☐ Suicide 4 ☐ Homicide	6 Could determ	inad   200. FI	lace of injury uilding, etc.	r - At home (Specify)	, farm, str	eet, facto	y, office				on (Stree Town, S	t and Numbe tate)	er or Rui	al Route Ni	ımber,
20			00- 0	Normale .	ng Physician: To	the best of	my knowle	dae doct	h occurre	at the fi	me date	and place	and due to	the caus	e(s) and ma	nner as	stated.	
(7	Hospital 24 hours a Funeral I	Medical	29a. Certifier (Check only one)	2 Medical	Examiner: On th	o the best of he basis of e manner state	xamination	age, deat and/or in	vestigatio	n, in my	opinion, d	eath occu	rred at the ti	me, date	and place,	and due	to the cause	e(s)
- )	To the within 2 To the comple	Med	29b. Signature an	d title of certifie		1	1		29	c. Licens	se number			29d.	Date signed	(Month	Day, Year	)
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	0 /		30. Name and add	dress of person	who completed o	cause of dea	th (Item 23	a) (Type,	Print)	0.2		21/2	20	Re	1201	ton	210	121
	10		Dr ANUS	HA. SI	RITHARA	$\frac{7}{2}$	60 GF	716A	VAY	DIL	VG.	21/2	2B,	1001	mr, I	11)		
	Sta	ate	31. Date filed (Mo	onth, Day, Year		2 Registrar	's Signature		self.	9		/						

DHMH 17 Rev 1/2001

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Seitz 4:45 AM blones )ctuber 2007 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Augsburg Lutheran Home Baltimore Baltimore 8. Date of Birth (Month, Day, Year) July 21,1912 If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 □ M 2 🖸 🕱 95 216-03-3290 Maryland Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Baltimore Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6825 Campfield Road 21207 United States 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2XI If Yes, Give Year or Dates: 1 Never Married 2 Married 2**X**XIO 1 ☐ Yes 2XXNo Specify: 3 Vidowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Physical Inspection Western Electric 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William F. Weis Mary Elizabeth Ovelgone 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frances Deluca niece 918 Delray Drive Forest Hill, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Lake View Mem. Park Oct. 11, 2007 Sykesville, MD 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 Denation 5 ☐ Other (Specify) 21. Signature of Funeral Service dicensee 22. Name and Address of Facility Burrier-Queen Funeral Home & Crematory, PA 1212 W. Old Liberty Road Sykesville, MD 21784 e, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. 3a. Part . Enter the disease sho k, or heart failure. Immedia e Cause (Final disease or condition resulting in death) Alzheimeris Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4 □ Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 🗌 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 □ No 2 No 1 TYes 1□ Yes

**Physician** /Medical Examiner

Department of Important: If it any injury or o once.

**Physician** 

/Medical

Examiner

**Funeral** 

Director

r 28a-f show notified at

rral", or items 23a or Examiner must be

"natural"

7 is marked other than "natu traumatic event, the Medical

Pages 1 and 2 should be f nent of Health and Mental

of Health a

Director

Funeral

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Completed

Be

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filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

sician and burial-trans physi the b attending ph for use as the certificate has been s rector, page 2 should After this

To the Hospital or Attending Physician: The law requires that the death certificate be executed

Examine Physician/Medical Be Completed by Certification: To Medical

within 24 hours after death.

To the Funeral Director: A
completely filled in by the fu completely

Division or Vital Records, P.O. Box 68760

25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 🗂 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only

29b. Signature of certifier

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

00053337

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Avenue Suite 203 2835 Smyth m) 32. Pagistrar's Signature 31. Date filed (Month, Day, Year)

State Registrar

OCT 0 9 2007

		1 - For State Registrar	State of Maryland / D	Department Certificate				00	0.7	22266
		Registrar  1. Decedent's Name (First, Middle, Last)		Ochimodic	, or bean	1	2. Date of Dea	ith	U /	3. Time of Death
Phys /Me	ician dical	Wilbur Joseph	Shannon				Month October	- 6 200	/	5:10 PM
Exan	niner	4a. Facility Name (If not institution, give stre			own, or Location			4c. County		14 -00
	ð	5 Social Security Number 6. Sex.	7. Age (In yrs. last bir		Year If Und		8. Date of Birth		3 Ritholac	ce (State or Foreign
Funer: Directo				Yrs. Months	Days Hours		(Month, Day	Z. 1920	Country	),
		Usual Residence of Decedent					11104 0	7.12	1	100170
arylan show d at	یا	10a. State 10b. County	10c. City, Tow						10d	I. Inside City Limits  1 ☐ Yes 2 No
ne Ma 8a-f s	ecto	Maryland Battim	ore l	Baltimor						
with the	ä	10e. Street and Number 2121 Gaylawn	Natio	10f. Zip	2/22	27		10g. Citizen of W	nat Country	?
d 21215-0036 filed within 72 hours after death with the Maryland Hygiene. wher than "natural", or Items 23a or 28a-f show ent, the Medical Examiner must be notified at	Funeral Director	11. Marital Status 12.	Was Decedent Ever in U.S.	13. Was Deced			cify Yes or No-	14. Race	- American	Indian,
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036 ours a ral", o	À	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 2	No Specia	fy:		Specify:	Wha	te
21215-0036 d within 72 hours af giene. ar than "natural", or the Medical Exami	Completed	15. Decedent's Educat (Specify only highest grade c		Decedent's Usua (Give kind of wor	k done during m	ost of worki	ng [	16b. Kind of Bu	siness/Indus	stry
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laryland 2 2 should be filed and Mental Hygi Is marked other aumatic event, #	-	19a. Informant's Name/Relationship (Type.		Mailing Address	(Street and Nun	nber or Rura		t		ode)
and 2 and 2 m 27 is m 27 is her train		Donna Perry / Do	wahter 2	-121 Gay	laun D	rive	Baltin	work, M.	D 212	27
or te		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Ren	comete	Disposition (Namery, crematory or or	hornigon		Date	20c. Location -	City or Town	n, State
Pages ment of H ant: If Ite ury or o		4 Donation 5 ☐ Other (Specify)	Another Another	Biffs Rea	stry	October	16,2007	Honore	F, MI	)
Baltimore, permit. Pages 1 ar Department of Hea Important: If Item any Injury or othe	ouce,	21. Signature of Funeral Service Licensee		22. Name and	Address of Fac	cility And	uterry Gi-	As Regio	stry	D21076
	OI .	1 15025		75ZZ G	melley	Drive	Sulte	t, HAN	こしどうん	W21076
ALC: N		23a. Part1. Enter the disease, or complica shock, or heart failure. List only one Immediate Cause (Final		not enter the mode	e or aying, suon	as cardiac o	or respiratory an	rest,	l lr	Approximate Interval Between Onset and Death
Physicia /Medica	_	disease or condition resulting in death)	ALHEIMER'S  Due to (or as a consequence	A6.					_	
Examine	_		Due to (or as a consequence	01).						
	je je	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequence	of):						
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50, e exe sian a uriat	Ě	resulting in death) Last	Due to (or as a consequence	of):						
icate be executed physician and sthe burial-transit	dical	d								
± on e	l o	IF FEMALE: 23c	If yes, outcome pf pregnancy					Ood Det		
BG leath	cian	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death	3 ☐Ectopic pro				Mor	e of delivery oth Da	ay Year
the cay the ached	hysi	9 Unknown	9□Unknown							
Vital Records, P.O. Box 6 sician: The law requires that the death certificater has been signed by the attending rector, page 2 should be detached for use as	by Physician/M	Part II. Other significant conditions contri	buting to death but not resulting in	the underlying ca	use given in Par	rt I.	23e. Did to	bacco use contr	ibute to the	cause of death?
ord en sig	ed k						1 🗆 Y	′es 2 □ No	3 ☐ Probab	oly 4 <b>X</b> Unknown
0 8 8	plet						24a. Was a		Vere autops	y findings available pletion of cause of
The The page	Completed						perfor 1 Yes	rmed?	leath? □Yes 2	
Vital I iician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?				ace of Death	(Check only o	ne)		
Or Physical this call direction	2	1 res 2 140	pital: 1 ☐ Inpatient 2 ☐ ER/Ou 28a. Date of Injury 28b.							HOSPICE
Division or lor Attending Phys after death. Director: After this in by the funeral dir	ion	1 Natural 5 Pending 2 Accident investigation		njury M	Bc. Injury at Work? 1 ☐ Yes 2		zou. Describe n	sow injury occurr	ea	
Attender death death ctor:	ficat	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of injury - At home, fa				28f. Location (S	Street and Numbe	er or Rural F	Route Number,
Div after I Dire	Certification:	4 Homicide determined	building, etc. (Specify)				City or Tow	n, State)		
Divisite a Hospital or Attence 24 hours after death a Funeral Director: etely filled in by the		29a. Certifier 1 Certifying Physic	ian: To the best of my knowledger: On the basis of examination ar	e, death occurred	at the time, date	and place,	and due to the	cause(s) and ma	nner as stat	ed.
Division or Vital Reform to the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Medical	one)	and manner stated.							
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1					775	125		10/	8/07	
1		DR. TARIO MAHMOOD			TTMO:	NTIN	MD 2104	2		
	State	31. Date filed (Month, Day, Year)	2300 DULANEY V	WPPEI KD	• IIMO	NTOM.	MD 2109	33		

Registrar



DHMH 17 Rev 1/2001

OCTOBER 6, 2007

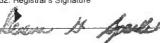
SHANNON, WILBUR

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

29b. Signature and title of cert

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ST PAUL PL, BACTIMORE MD 21202 32. Registrar's Signature



29c. License number

D0058842

29d. Date signed (Month, Day, Year)

Oct 10, 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amendiated Markand Besartneth of Healt Mand Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 29 2007 Si'Nai Monique Simons JU/4 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Baltimore Sinai Hospital If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Hours 20 Months Yrs. 1 □ M 2 □ F maryland JULY 29, 2007 UNKNOWN Director Usual Residence of Decedent 10d. Inside City Limits should be filed within 72 hours after death with the Maryland not Mental Hygiene. 10c. City, Town or Location 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 1 Yes 2 No Baltimore md **Funeral Director** 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 2603 Reisterstown Rd #3 USA 21215 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 D No If Yes, Give Year or Dates: 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Blac Baltimore, Maryland 21215-0036 Be Completed by 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) none ハロハと nont ハロハと 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Simons UNKNOWN ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Baltimore, 121215 BELVEDETE Sinai Hospital 2401 W. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) #05 ₽17 ☐ 929 Sinai Hospital 21. Signature of Funeral Service Licensee DISPOSA 22. Name and Address of Facility JINA, HOSP, 240/ W. Belvenere Ave BALTIMORE, MI 2401 W. arl 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 20 hrs Extreme Physician Due to (or as a consequend of): /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) The law requires that the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, the attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months?
1 Yes 2 No
9 Unknown 4☐Pregnant at time of death 5 Other (specify) 9 Unknown care nas been signed by t page 2 should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 1 ☐ Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an perform 25. Was case referred to medical examiner? 26. Place of Death Check onl one funeral director, 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 3□ DOA Medical Certification: To 2 ER/Outpatient After this 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? 1 Natural 2 Accident 5 Pending investigation within 24 hours after death.

To the Funeral Director: Af
completely filled in by the fu 1 ☐ Yes 2 ☐ No 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier July 29, 2007 Baltimore, 30. Name and address of person who completed cause of Jeath (Item 23a) (Type, Print) H05 2401 W. BEIVEDETE AVE 31. Date filed (Month, Day, Year) State Registrar DHMH 17 Rev 1/2001

**ORIGINAL** 

3

Physician /Medical Examiner for Attending Physicism: The law requires that the death certificate be executed effer death attending physicien for use as the burial Box 68760, Records, P.O. ivision of Vital After this within 24 hours elter death To the Funeral Director: completely filled in by the

Maryland 21215-0036

more,

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge death oncurred at the time, date and place, and due to the eause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) DOO 61832 2007 OCTOBER

10

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SA1412 JAIN Hospital Drive, Glen Burnie, MD 21061 31. Date filed (Month, Day, Year)

State Registrar



#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 200 Martha Szerlip /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner N/A Union Memorial Hospital Baltimore 8. Date of Birth (Month, Day, Year) APR 12 1930 If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number 6 Sex **Funeral** Months 1 □ M 2X F Days Hours New Jersey 148-24-8272 77 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a, State show 1 XYes 2 □ No 28a-f sh **Funeral Director** MD N/A Baltimore death with the 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ms 23a or 7 21211 USA 321 Wyman Park Drive 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: permit. Pages 1 and 2 should be filed within 72 hours after deat Department of Health and Mental Hygiene. Important: If them 27 is marked other than any injury or other traumation. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 7 is marked other than "natural", or items traumatic event, the Medical Examiner mo 11 Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2**X** No Specify: Be Completed by White 3 ☐ Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Sculptress Fine Arts 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Sarah Dvorken Eva Leopold Szerlip ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 321 Wyman Park Drive, Baltimore, MD Maya M. Reid - companion 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Metro Crematory, Inc. 10/4/2007 Baltimore, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee H. Williams Name and Address of Facility Cremation Society of Maryland, Inc. 299 Frederick Road, Baltimore, MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** nopord adtrom'x /Medical Due to (or as a consequence of): Examiner trel your Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical IF FEMALE: 23d. Date of delivery 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 □Ectopic pregnancy Day Month Vear in the past 12 months2. 1 ☐ Yes 2 ☐ NO 4☐Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown 9 Unknown þ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 24a. Was an autopsy performed? 2 1/1 1 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 No 1 Impatient 2 ER/Outpatient 3 DOA Certification: To After this 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 4 ☐ Homicide

Division or Vital Records, P.O. Box 68760, To the Hospital or Attenuary
within 24 hours after death.

To the Funeral Director: Aft

- Market filled in by the fur

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State

31. Date filed (Month, Day, Year) Registrar

Medical

29a. Certifier

(Check only

29b. Signature and title of certifier

OCT 0 9 2007

and manner stated.

Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 Decrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

2007

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

32271 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Physician Month 2007 10:20 a<sup>M</sup> Margaret Sperato October 0 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gilchrist Center for Hospice Care Baltimore Towson if Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year JUN 3 1921 Birthplace (State or Foreign Country) 5. Social Security Number Age (In yrs. last birthday) **Funeral** 1 □ M 2 1 F Months Days Hours 86 Maryland Director 216-38-7131 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No notified Director Baltimore Towson 28a-f 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? ö must be 509 E. Joppa Road 21286 IISA 238 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, : If Item 27 Is marked other than "natural", or Items or other traumatic event, the Medical Examiner man 11 Marital Status Black, White, etc. 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🛣 No Be Completed by Specify 3 X Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and 2 should be fil lealth and Mental H m 27 Is marked oth Bast James Loretta Johns 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If Item 27 Is
any injury or other trau Lisa Webster - granddaughter 5611 Carrington Drive, White Marsh, MD Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Metro Crematory, Inc. 10/8/2007 Baltimore, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility.
Cremation Society of Maryland,
299 Frederick Road, Baltimore, Williams ull 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ASPIRATION PNEUMONIA **Physician** DAYS /Medical Due to (or as a consequence of): Examiner MENTIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dusity for as a consistence of Examiner the burial-tran Due to (or as a consequence of) P.O. Box 68760 Physician/Medical as IF FEMALE: use 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Day Month Year 4□Pregnant at time of death 9□Unknown ate has been signed in page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records. Be Completed by PHYSEMA 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown FIBRILLATION 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1□ Yes or Attending Physician: rector. 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence State (Specify) 1 ☐ Yes 2 P 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 latural 2 ☐ Accident Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: 6 ☐ Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Hospital Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of D64395 OCTOBER 7,2007 of person who completed cause of death (Item 23a) (Type, Print) 30. Name and DANIEUE DOBERMAN, MO 6565 N CHARLES ST, SUITE 209 BALTIMORE, MD 21204 2. Registrar's Signature 31. Date filed (Month, Day, Year) OCT 0 9 2007

Registrar

at 10a0AM

7,2007

Sperato, Marya

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 32272 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician 5.55 PM 100 1) 2007 /Medical 4a. Facility Name (If not institution, give street and number, 4b. City. Town, or Location of Death 4c. County of Death Examiner Cntr. Baltimore-Washington Med. Anne Arundel Glen Burnie If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days 1 <del>M</del> M 2 □ F Director 215-60-7066 55 June 12, 1952 Japan Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a, State r 28a-f show notified at show 10d. Inside City Limits Director 1 ☐ Yes 2 ☑ No Anne Arundel Glen Burnie MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or edical Examiner must be r 7943 Pipers Path 21061 USA Funeral permit. Pages 1 and 2 should be filed within 72 hours after deal Department of Health and Mental Hygiene. Important: If item 27 is marked other the any injury or other trainment. 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🕱 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify 2 Specify: Asian 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Pressman Newspaper 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ၉ John A. Szczepanik, Jr. Teruko Sato 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Deborah Ikerd/ Sister 209 Sportsmans Neck Rd., Queenstown, MD 21658 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State October 9, 4 □ Donation 5 □ Other (Specify) Baltimore, MD Stanislaus Cem. 2007 22. Name and Address of Facility
Singleton Funeral and Cremation Services 21. Signature of M01411 2nd Ave. SW, Glen Burnie, MD 21061 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner The law requires that the death certificate be executed 000 85 19 and use as the burial-trail Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, s been signed by the attending physician should be detached for use as the buria IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death Month Day Year 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 🗌 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has page 2 autopsy 1☐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica (completely filled in by the funeral director, p. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Yes Hospital: Other: 4 Nursing Home Inpatient 2 □ No Certification: To 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) er of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 2 Accident 5 Pending investigation 1 Tes 2 🗆 No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital o within 24 hours af To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who of death (Item 23a) (Type, Print) 127GBWB1

State Registrar 31. Date filed (Month, Day, Year)

OCT 0 9

			For State Registrar	State of Maryland	d / Department of H Certificate of			2007	32273
	Physicia		1. Decedent's Name (First, Middle, Last)		Swand	500 1	. Date of Death Month	Pay Year Zoo	3. Time of Death 7 15:35 M
	/Medic Examin Funeral	er	4a. Escritiy Name (If nor institution, give stands of the Johns Hope) 5. Social Security Number 6. Sex	UNS HOSPI	tal Balt	or Location of Death	City	4c. County of Deat	h hplace (State or Foreign
	Director		501-48-4800	<sup>M 2</sup> □XF 64	Yrs. Months Days	Hours Min.	arch 29,	1943 Ca	ifornia
	Maryland	tor	10a. State 10b. County Virginia Fairfax		Town or Location exandria				10d. Inside City Limits 1 Yes 2 No
	with the	Direc	10e. Street and Number		10f. Zip Code			Citizen of What Co	untry?
36	d within 72 hours after death with the Maryland jiene. r than "naturel", or items 23a or 28a-f show the Madical Exantine roual be motified at	by Funeral Director	6306 Yosemite Dri  11. Marital Status 1  Never Married 2 Married  3 St Widowed 4 Divorced	2. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 XNo If Yes. Give	22312 S. 13. Was Decedent of H f Yes, specify Cub 1 \( \triangle \text{Yes} \) 2\( \text{\$\mathbb{Z}} \) No	dispanic Origin? (Specian, Mexican, Puerto Ri		USA  14. Race - Ame Black, Whit  Specify: WI	e, etc.
21215-0036	c 1	Completed b	15. Decedent's Educ (Specify only highest grade	ation completed) College (1-4or 5+) 5+	16a. Decedent's Usual Occup (Give kind of work done life. DO NOT use retire	pation during most of working d)	7 16b	Kind of Business	
<u>d</u> 2	i i i i i	Be Co	12 17. Father's Name (First, Middle, Last)	5+	Teacher	18. Mother's Name (	First, Middle, Maid	Teaching	5
Maryland	0 2 0	ToB	Jack Franklin		,	Iris		ogene	Smith
Baltimore, Mar	ges 1 and 2: 1 of Health at If item 27 is or other trac		19a. Informant's Name/Relationship (Type Christina Svendsen 20a. Method of Disposition  1 □ Burial 2 ☑ Cremation 3 □ Re  4 □ Donation 5 □ Other (Specify)	(Daughter)	19b. Mailing Address (Street  381 Harvard Stace of Disposition (Name of pretery cremator) or other 812 Loudon Park	St., Cambri	dge, MA	02138 Location - City or	
Balti	permit. Pa Departmen Importent: any injury once.		21. Signature of Funeral Service Licanse	100	22. Name and Addre	ens Ave., B			
8760,	Physician and // // // // // // // // // // // // //	edicai Examiner	23a. Page Trife the disease, or complications, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, Juading to minimate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence to (or as a consequence)	Suence of):  Myeloi  sunce of):	d Lew		ξ	Approximate Interval Batween Onset and Death 4 days  3 months
O. Box 6	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ 0 9 □ Unknown	ac. If yes, outcome of pregnar 1 □Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown	death 3 Ectopic pregnance	у		23d. Date of de Month	ivery Day Year
ds, P.	uires that n signed b	þ	Part II. Other significant conditions con	tributing to death but not resu	ulting in the underlying cause gr	ven in Part I.	23e. Did tobace		the cause of death?
al Records,	The ate h page	Completed					24a. Was an autopsy performed	?/ prior to death?	utopsy findings available completion of cause of
ion of Vital	To the Hospitel or Attending Physician: The within 24 hours after death.  22 the Funerel Director: After this certificate his completely filled in by the funeral director, page	ation; To Be	27. Manner of Death Natural 5 Pending investigation	ospital: Impatient 2 1 28a. ate of Injury (Month, Day Year)	28b. Time of lnjury Wo			e 6 Other (Spenjury occurred	city)
Division	el or Atte s after de si Directo ed in by th	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, street, factory, office	28	Bf. Location (Stree City or Town, S		ural Route Number,
	To the Hospitel or Attent within 24 hours after death Log the Funerel Director: completely filled in by the	edical (	29a. Certifier (Check only one)  Certifying Physical Certifying Physical Examination (Check only one)	ician: To the best of my knowner: On the basis of examinat and manner stated.	wledge, death occurred at the ti tion and/or investigation, in my	ime, date and place, ar opinion, death occurred	nd due to the caus d at the time, date	e(s) and manner a and place, and du	s stated. e to the cause(s)
<b>\</b>	withii comp	M	29b. Signature and title of certifier	Medical	29c. Licen			Date signed (Mon	
	5		30. Name and address of person who co	Medical mpleted cause of death (Item	Poctor RE 23a) (Type, Print)	> 000	, (	1000 -	> 2007
	'Y		JOYCE L-SANC	HEZ JOHNS 32. Residerar's Signal	HOPKINS HOSP	1TAL,6001	Vorth Wol	fe Street,	S 2007 Baltimore, NO 2125
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Physician /Medicai Examiner

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Certification:

Medical

The law requires that the death certificate be executed

To the Hospital or Attending Physician; within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director,

Division or Vital Records, P.O. Box 68760,

Department of Health a Important: If item 27 is any injury or other tra

**Physician** 

Examiner

Funeral

Director

show

Director

Funeral

Completed by

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Md.

7 is marked other than "natural", or items 23a or 28a-f shor traumatic event, the Medical Examiner must be notified at

Pages 1 and 2 should be filed within 72 hours after death

tal Hygiene.

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altimore, Maryland 21215-0036

/Medical

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Physician/Medical IF FEMALE:

25. Was case referred to medical examiner? 1 ☐ Yes 2 No 27. Manner of Death 1 Natural

2 Accident

3 Suicide

29a. Certifier

4 Homicide

5 Pending investigation 6 ☐ Could not be

determined

1 npatient 28a. Date of Injury (Month, Day Year)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 28b. Time of 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and the of certifier

29c. License number

29d. Date signed (Month, Day, Year)

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RESOOO

OCTOBER 6

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hospital:

OBISEAN SOUTH HANDVER STREET, BALTIMORE ADEKUNLE 3001 31. Date filed (Month, Day, Year) 0CT 0 9 2007 32. Registrar's Signature

State Registrar

State of Maryland / Department of Health and Mental Hygien 2007 For State Registre Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** а м Rita L. Stone 2007 October 0 /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore County Catonsville Manor Care If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) March 24 1939 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) Funeral 1 M 2 2 F 68 213-36-2222 Director Pennsylvania Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant of Health and Mental Hygiene. ant: If item 27 le marked other then "natural", or Items 23s or 28s-f show 10c. City. Town or Location 10d. Inside City Limits 10a, State 10b. County other treumatic event, the Medical Examiner must be notified at Md. 1 ☐ Yes 2 ☑ No Easton Director Talbot 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 1070 North Washington St. Apt. 1506 21601 Completed by Funeral 12. Was Decedent Ever in U.S.
Armed Forces?

1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Baltimore, Maryland 21215-0036 Specify: Specify: White 3 ☐ Widowed 4 ☑ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) MVA Clerk 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Staley Rita Nicholas Vinch 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Finksburg, Md. 21048 2664 Secretariat Dr. Deborah Fowler, Daughter Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State ō permit. Page Department of Importent: If any injury or once. Holy Cross Cemetery 10/5/07 Baltimore, Md. \* 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Gonce Funeral Service P.A. 21. Signature of Funeral Service Licensee 4001 Ritchie Hgwy. Baltimore, Md. 21225 nameroush 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician PULMONARY LHRONIC OBSTRUCTIVE DISEASE disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, farry, leading to in module cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a considuence of by Physiclan/Medical Examiner Hospital or Attending Physicien: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) Box 68760. as the t IF FEMALE: esn. 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day ğ in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. the detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed 1 ☐ Yes 2 ☐ No 2 No Division of Vital funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No Certification; To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending investigation after death. 1 TYes 2 □No 2 Accident 3 🗀 Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical within 2 To the the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number A 10-2-2007 M.D D0059107 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CENTERY DRIVE UMA REISTERSTOWN 210 BUSINESS. 37 Registrar's Signature 31. Date filed (Month, Day, Year) 0 9 2007 State Registrar

			For State Registrar	State of	f Maryla	nd / Depa	artment of F rtificate of	lealth ai Death	nd Menta	l Hygie <sub>Reg.</sub>	ne No. 200	7 32278
by .	Physici /Medi		1. Decedent's Name (First, Midd Lillian	R. Streck	fus				2. Date Mon Octo	of Death	5 2007 Pea	<ol><li>Time of Death</li></ol>
	Examir	er	4a. Facility Name (If not instituti Gilchrist	on, give street and nun	nber)		4b. City, Town, o	r Location of	Death		4c. County of De Baltimo	
	Funeral Director		5. Social Security Number 212–18–7500	6. Sex 1 ☐ M 2 <b>X</b> F	7. Age (In yr.	s. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hours	Min. (Mor	of Birth oth, Day, Ye	ear)	Birthplace (State or Foreign Country) aryland
	e Maryland 3a-f show tified at	ctor	Usual Residence of Decedent  10a. State  10b. Count  Md.  Balt	timore		City, Town or Lo						10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	h with th	al Dire	10e. Street and Number 8800 Walther E	31vd. #2605	;		10f. Zip Code 2	1234		10g.	Citizen of What	Country? USA
920	urs after deat al"; or Items 2 Examiner πυ	by Funeral Director	11. Marital Status  1 Never Married 2 Ma 3 XWidowed 4 Divorce	If Yes, Giv	rces? 2 X No /e		Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 🛣 No	lispanic Origi an, Mexican, Specify:	n? (Specify Yes Puerto Rican, e	or No-	Black, W	merican Indian, hite, etc. White
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show amy Injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by	15. Decede (Specify only high Elementary/Secondary (0-12)	ent's Education lest grade completed) College (1	-4or 5+)	(Give	dent's Usual Occup kind of work done DO NOT use retired	ation during most of d)	of working	- 1	Dwn Home	ss/Industry
Maryland	uld be file Aental Hy rked othe tic event,	To Be C	17. Father's Name (First, Middle Howard C. Ric	•					s Name <i>(First, I</i> Daisey		den Surname)	
Mary	and 2 shore alth and A 27 is mast trauma		19a. Informant's Name/Relation June Strekfus	nship <i>(Type. Print)</i> S/ Daughter	•	1	ng Address <i>(Street</i> )11 Trale				ity or Town, State	
Baltimore,	Pages 1 a lent of He nt: If item ry or othe		20a. Method of Disposition  1 ☐ Burial 2 ☒ Cremation  4 ☐ Donation 5 ☐ Other		State	cemetery, cre	osition (Name of matory or other place Co	′ i	Date 0-8-07		C. Location - City	
Balti	permit. Departm Importal any Inju		21. Signature of Funeral Service		2		2. Name and Addre Ruck Tov 1050 You	ss of Facility	uneral	Home.	Inc.	114.5
THE PERSON	Physician /Medical Examiner	ner	23a. Part1. Enter the disease, shock, or heart failure. Li Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate	Due to (		4SEW equence of):		ng, such as c	ardiac or respira	atory arrest		Approximate Interval Between Onset and Death YEMPS
58760,	icate be executed physician and the burial-transit	dical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c Due to (	or as a conse	equence of):						
.O. Box (	e death certifi he attending I ied for use as	Completed by Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		oirth 2□Fe nant at time o	etal death 3	□Ectopic pregnanc □ Other (specify)	/			23d. Date of Month	delivery Day Year
ds, P.	g g	d by Pł	Part II. Other significant condi	itlons contributing to de	eath but not re	esulting in the u	nderlying cause giv	en in Part I.	236			e to the cause of death? Probably 4 □Unknown
al Records,	The law ate has be	Complete								a. Was an autopsy performe Yes 2	prior	
r Vital	Physician: Th this certificate al director, pag	To Be	25. Was case referred to medic examiner? 1 ☐ Yes 2 No	Hospital:	Inpatient 2	☐ ER/Outpatie	nt 3□ DOA Oth		of Death <i>(Check</i>		e 6 Monther (S	pecify) HOSPICE
Division or	ing After uner	Certification: T	3 ☐ Suicide 6 ☐ Coul	d not be	th, Day Year)		Wor		28d. De	scribe how	injury occurred	Rural Route Number,
Div	urs after ral Dire	Certif	4 I Torricide	buildi	ng, etc. (Spe	cify)			City	or Tówn, S	State)	
	To the Hospital or Attendi within 24 hours after death.  To the Funeral Director: /	Medical	(Check only 2 Medic one)		best of my k asis of exami ner stated.	nowledge, dea ination and/or i	nvestigation, in my	opinion, deat	place, and due h occurred at th	to the cause time, date	se(s) and manner and place, and	r as stated. due to the cause(s)
	To t To T	Σ	29b. Signature and title of certification	The Day	~		29c. Licens	e number	Q E	29d	Date signed (Me	onth, Day, Year)
,	15		30. Name and address of person DANIEW DIB 31. Date filed (Month, Day, Year OCT	on who completed caus	se of death (It	em 23a) (Type	Print)	84.118	209 4	BALTT	MARE M	0 21204
ľ	Sta Regist	ate rar	31. Date filed (Month, Day, Yea	) 9 2007 A	sistrar's Sig	nature /	berli					

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 2007 October 0 10:10p M Constance Snow Shepler /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Brighton Gardens Towson 8. Date of Birth (Month, Day Year) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours 032-05-1547 1 ☐ M 2 👿 F Maine 91 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If Item 27 is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notifiled at Baltimore 1 □Yes 2 XNo Md. Towson Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 804 Stone Barn Road 21286 USA 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 □ Yes 2 🛣 No If Yes, Give Year or Dates: 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify: White 2 3 X Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Real Estate Agent Real Estate 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Robert Asbell Snow Harriet Mae Carver 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Janet Vermehren-Shepler/ Daughter 1043 Saxon Hill Dr. Cockeysville, Md. 21030 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Important: If ite any Injury or ot 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State Hilltop Service Co. 10-9-07 Towson, Md. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility. Ruck Towson Funeral Home, 1050 York Rd. Towson, Md. 21. Signature of Fux ral Sylvice 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Jause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical as the 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) ed by the 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? page 2 should be 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an has certificate 1☐ Yes 2☐ No funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 27. Manney of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Matural 5 Pending investigation Injury 1 Yes 2 No 2 Accident 6 ☐ Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

or Attending hours after deat Hospital

within 24 hours a To the Funeral L

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, State Registrar

4 Homicide

(Check only one)

29b. Signatur and title of certifier

29a. Certifier

30. Name and

ddress of person who completed cause of death (Item 23a) (Type, Print) 702 W. You **G**giştrar's Signature Year.

**ORIGINAL** 

1 🗗 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year) 8.07

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician Anasuya Sharma October 7, 2007 3:27 AM Κ. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Suburban Hospital Bethesda Montgomery If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Days, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday 5. Social Security Number 6 Sex **Funeral** Days 1 □ M 2 💢 F 85 April 15, 1922 India Director 578-54-4982 Usual Residence of Decedent 72 hours after death with the Maryland 10d Inside City Limits 10c. City. Town or Location 10a. State 10b. County "natural", or Items 23a or 28a-f show dical Examiner must be notified at 1X Yes 2 No Director D.C. Washington 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 4801 41st Street, N.W. United States 20016 Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 X No Specify Specify: Asian Indian ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wil Department of Health and Mental Hygien Important: if item 27 is marked other the any Injury or other traumatic event, the once. 욢 Physician Medicine 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Gundu Rao Seshamma ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 4801 41st Street, N.W. Washington, D.C. Amar Nath Sharma/Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition October 8, 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) Montgomery Crematorium 2007 Bethesda, Maryland 22. Name and Address of Facility Robert A. Pumphrey Funeral Home, Bethesda—Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814 21. Signature of Funeral Service License Mulkan a M01173 23a. Part1. Enter the disease, or complications that of used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SEPSIS **Physician** /Medical Due to (or as a consequence of): PERFORATION Examiner COLON Sequentially list conditions, from the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) Physician/Medical the nse 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 No 9 ☐ Unknowh 3 □Ectopic pregnancy ē Month 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached f 9☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 2**X** No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dii 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 | Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated

Baltimore, Maryland 21215-0036

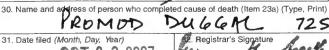
Division of Vital Records, P.O. Box 68760.

Registrar

31. Date filed (Month, Day, Year) State OCT 0 9 2007

29b. Signature and title of certifier

PROMOD





MD

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav **Physician** 4, 2007 PHILLIP McKAY SUTLEY 12:46P M October /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MERCY MEDICAL CENTER N/A Baltimore City 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday, **Funeral** Days 503-40-4670 66 Director Jan 10, 1941 Maryland Usual Residence of Decedent 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1X Yes 2 □ No Director N/A Maryland Baltimore City 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 110 S. Patterson Park Avenue 21231 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Xi Yes 2 □ No 162-165 If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black, White, etc. 72 hours after 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No White Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) filed within Hygiene. d 2 should be filed within the and Mental Hygiene.
7 Is marked other than " College (1-4or 5+) 5+ Elementary/Secondary (0-12) Legal Profession Attorney at Law 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Percy Paul Sutley Cathryn McKay မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 st Department of Health and Important: If item 27 Is n any Injury or other traun Mrs. Deborah Sutley (Wife) 110 S. Patterson Park Avenue, Baltimore, MD 21231 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Green Mount Cemetery 10/8/2007 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Servity Licent 22 Name and Address of Facility
MITCHELL-WIEDFFELD Funeral Home, 1110.
6500 York Road, Baltimore, Maryland 21212
Approximately arrest, Approximately arrest, Interval Name and Address of Facility ITCHELL-WIEDEFELD Funeral Home, Inc Robert M. Kratz 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death PULMONARY EMBOLISM Immediate Cause (Final **Physician** MMEDIATE disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of be executed CHERECHSTITES burial-trar Due to (or as a consequence of) P.O. Box 68760, physician Physician/Medical use as the IF FEMALE: 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a 9 Unknown 9 Unknown s been signed by the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, ģ 1 Yes 2 No 3 Probably 4 hknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ▶ es 2 □ No 24a Was an certificate has page 2 autopsy 1XYes 2 No or Attending Physician: 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 XER/Outpatient 3 □ DOA 1 Inpatient Certification: To After this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 X Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Hospital 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0051140

Registrar

2

State

MODELY MEDICIN CENTRE 301 ST. ANL RICE, BALD, MD 21202

ess of person who completed cause of death (Item 23a) (Type, Print)

3 Registrar's Signature

horsomy MD.

			1 - For State Registrar	State of M	aryland		artmen tificat			ind M		iene g. No.	7 3	32280
	Physicia	20	1. Decedent's Name (First, Middle, Las	t)							2. Date of Deat	h Day Ye	ar .	Time of Death
	/Medic	_	MARY DANNER ST								UCTOD	dr 03 20		5-120 PM
	Examin	er	4a. Fecility Name (If not institution, give Genesis Loch Rav		)				Location o	f Death		4c. County of E		
	Funeral		5. Social Security Number 6. Se		ge (In yrs. Ia	ast birthday)		altin	IOTE	24 Hrs.	8. Date of Birth	9	imore Birthplace	
	Funeral Director			⊒м 2√2 F	87	Yrs.	Months	Days	Hours	Min.	Jan. 9,	L920 Ma	Country) arylar	(State or Foreign
	p ,		Usual Residence of Decedent  10a, State 10b, County		10- 0:-	, Town or Lo							404	Inside City Limits
>	ehov	'n	10a. State 10b. County Maryland Baltimor	·e		1timo								1 □ Yes 2 No
,	28e-1	rect	10e. Street and Number				10f. Zip	Code			1	0g. Citizen of Wha	t Country?	
	3a or	0	8720 Emge Road					L234				U.S.		
	deatl	Funeral Director	11. Marital Status	12. Was Decedent	Ever in U.S	S. 13.1	Was Dece	dent of Hi	spanic Orig	gin? (Spe	crty Yes or No- Rican, etc.)	14. Race - A	American II White, etc.	ndian,
36	filed within 72 hours after death with the Maryland Hyblene. Hyblene ther then "neturel", or items 23a or 28e-f ehow ther then "neturel", or items 23a or 28e-f ehow int. Ite Medical Examinar must be notified at	y Fu	1 Never Married 2 Married	Armed Forces: 1 ☐ Yes 2 ☑ If Yes, Give	No		1 ☐ Yes		Specify:	, , , , , , , , , , , , , , , , , , , ,		Specify:	Whit	te .
Ö	hours ture!	ed by	3 ☐ Widowed 4 ☐ Divorced  15. Decedent's Ed	Year or Dates:	1	16a. Dece	dont's Heu	al Occupa	ation			16b. Kind of Busin		
15	n "ne	Completed	(Specify only highest gra		5.1	(Give	kind of wo	rk done d	turing most	t of workir	ng	TOD. PRING OF CUSIN	0331113030	''
212	d with glene pr the	mo.	Elementary/Secondary (0-12)	College (1-40)	5+)		Mana	ger				Bakery	7	
pu	be file tal Hy of oth	Be	17. Father's Name (First, Middle, Last)		_							Maiden Sumame)		
Уa	2 should be filed within and Mental Hyglene. ie marked other then eumatic event, I'm Ma	၉	Henry		ע	anner		/72		11ia		A: - T - A:	Luc	
Maryland 21215-0036	s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Marylan Hygiene 1 Health and Marylan Hygiene 1 Health and Marylan Healthen "neturel", or Items 23a or 28e-f ehow other treumstic event, Ite Medical Examination must be notified at		19a. Informant's Name/Relationship (7) MS Joanna E. Biscoe		r		•					Own, Penns		
	permit. Pages 1 and 2 Depertment of Heelth a Importent: if Item 27 is eny injury or other tre ance.		20a. Method of Disposition		20b. Pl	ace of Dispo	sition (Na.	me of	1			20c. Location - City		
Baltimore,	Pages nent of int: if it		1 N Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify		<b>9</b>	eland M				0-8-0	7	Baltimore, N	/bre1ar	rd
alti	permit. Depertmitimporte eny infu		21. Signature of Funeral Service Licen	700C			2. Name a	nd Addres	s of Facilit	Mitc	hell-Wied	efeld F.H.	Inc.	
_	80 E 2 8		1 Collect 1	Sight		1						Maryland 21	.212	
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	one cause of each	the death	. Do not ent	er the mod	de of dyin	g, such as	cardiac o	r respiratory arr	est,	Inte	proximate erval Between iset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a	12/	ner	100	9_					1	
	Examiner			Due to (or as	s a consequ	ience of):								
		Jer	Sequentially list conditions, I are leading to in modate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as	s a nonsagu	ience of).							_	
Qu.	cuted nd ransit	amir	that initiated events	c										
3,0928	cate be executed physicien and the burial-transit	EX	resulting in death) Last	Due to (or as	s a consequ	uence of);								
876	physic physic the b	dica		. d.									=	
Box 6	The law requires that the death certificate be executed ate hes been signed by the ettending physicien and bage 2 should be detached for use as the burial-transit	Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	e of pregnar	ncy						23d. Date o	f delivery	
Ã.	death e etter	Iclar	in the past 12 months?	1☐Live birth 4☐Pregnant a			Ectopic p Other (s					Month	Day	y Year
P.0	that the de led by the e detached f	hys	9 □ Unknown	9□ Unknown							1			
8,	iw requires that s been signed b should be deta	Ď	Part II. Other significant conditions c	ontnbuting to death	but not resu	alting in the u	nderlying (	cause give	en in Part I.	•		bacco use contribu		
Records,	requi	Completed										1	Probably	
<b>3ec</b>	hes t	mpi									24a. Was a autop: perfor	in 24b. Wei sy prio med? dea	e autopsy r to comple th?	findings available etion of cause of
la	icien: The l certificate he rector, page	မ ငိ	25. Was case referred to medical						06 Bl		1 ☐ Yes	200 No 1 🗆	Yes 2	(No
of Vital	Physicien: r this certifice ral director, p	To B	examiner?	Hospital: 1 ☐ Inpat	tient 2 🗆 I	ER/Outpatie	nt 3 🗆 D	OA Oth	or -		n <i>(Check only or</i> me 5 □ Resid	ence 6 Other	(Specify)	
סר	ter thi		27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Ing (Month, D		28b. Time o		28c. Injun Worl				ow injury occurred		
Siol	Attending in death.	catic	2 Accident investigation 3 Suicide 6 Could not be	1			М		Yes 2	No				
Division	or Atl	Certification:	4 Homicide determined	286. Place of II	njury - At ho etc. (Specify		reet, factor	y, office			28f. Location (S City or Tow	treet and Number ( n, State)	or Rural Ro	oute Number,
	pitai ours e ours e iiled	Ce	29a. Certifier 1 X Certifying Ph	ysician: To the bes	t of my know	wiedne deal	h occurred	at the tin	ne date an	nd place :	and due to the c	ause(s) and mann	er as state	d
	To the Hospital or Attending Ph within 24 hours eiter death. To the Funerel Director: After thi completely filled in by the funeral	edicai	(Check only 2 Medical Examone)	niner: On the basis and manner s	of examinat	tion and/or in	vestigation	n, in my o	pinion, dea	th occurr	ed at the time, o	late and place, and	I due to the	e cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier	(Ln. (-	. (	7/	29		e number			9d. Date signed (A		
			Mhla of	JUNUI	ng p	175	Ellh	· L	153	64	5	ato be	V 4	-2017
	1	V.	30. Name and address of person who	completed cause of	de (Item	23a) (Type	Printy	0	7	47	22 R	· Other	。 つ	1204
	Sta	ite	31. Date filed (Month, Day, Year)	32 Regis	trar's Signa	thro W	and to	17	1 ,	٠		acyin	~ ~	1604
	Regist		OCT 0 9 2	007	w L	5 /5/2	Contraction of the second							

Physician /Medica Examine

Funeral Director

		1- State of Maryland / Dep. State of Maryland / Dep. Registrar Amend #11, perFH, g872, 10/9/07 TT Ce		Reg. M	2007	32281
Physici		Decedent's Name (First, Middle, Last)  JULIUS	SOBER	2. Date of Death Month OCTOBER	2 2007	3. Time of Death 7:45P M
/Medic		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	7.431
		MANOR CARE - SILVER SPRING	SILVER SPRING		MONTGOM	ERY
uneral irector		5. Social Security Number  219-22-6665  Usual Residence of Decedent  6. Sex 10 M 2 F 7. Age (In yrs. last birthday 93 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, Yea 12/16/1	ar) Cou	place (State or Foreign ntry) MA
at ow		10a. State 10b. County 10c. City, Town or L	ocation			10d. Inside City Limits
a-f sh tified	ctor	MD PRINCE GEORGE'S MITCHE	LVILLE			1 ☐Yes 2 No
or 28	Director	10e. Street and Number	10f. Zip Code	10g. (	Citizen of What Cou	ntry?
s 23a nust l		2304 BERMONDSEY DRIVE	20721	neify Ven en Ne	USA 14. Race - Americ	an Indian
important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status  1 □ Never Married  2 ★ Merried  1 □ Never Married  2 ★ Merried  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Yes 2 ★ No If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 🎇 No Specify:	ecity Yes or No- Rican, etc.)	Black, White,	
'natur	eted	(Specify only highest grade completed) (Giv	edent's Usual Occupation e kind of work done during most of work	ing 16b.	Kind of Business/In	dustry
than he Me	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	OWNER		LIQUOR	STORE
other ent, t	Be Co	17. Father's Name (First, Middle, Last)		e (First, Middle, Maid		STORE
arked atic ev	To B	HARRY SOI	BER MOLLY		F	ELDMAN
' is ma			ing Address (Street and Number or Rui			,
em 27 other t		20a. Method of Disposition 20b. Place of Disp	BERMONDSEY DRIVE		Location - City or To	
rtant: If II njury or o		4 Donation 5 Other (Specify)  BETH J/		7/2007 FI	NKSBURG,	MD
any			8900 REISTERSTOWN	L LEVINSO		
288		23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.			NESVILLE	Approximate Interval Between
sician		Immediate Cause (Final disease or condition MULTI-ORGAN FAIL	URE			Onset and Death MONTHS
edical ıminer		Due to (or as a consequence of):  FAILURE TO THRIV	IC			MONTHS
a .	e	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	/ E			PIONTES
nd ransit	Examine	that initiated events c.				
cian a	EX	resulting in death) Last Due to (or as a consequence of):				
physician and s the bunal-transit	ledical	d				
<b>To the Funeral Director:</b> After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as	Physician/Me		□Ectopic pregnancy □ Other (specify)		23d. Date of deliv Month	ery Day Year
ed by detacl		Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacc	o use contribute to t	he cause of death?
n sign uld be	d by	OSTEOPOROSIS		1 ☐ Yes	2 No 3 Pro	bably 4 □Unknown
has bee e 2 sho	Completed	DEMENTIA		24a. Was an autopsy	prior to co	opsy findings available ompletion of cause of
icate l				performed? 1⊟ Yes 2 🔼	? death? No 1 ☐ Yes	2 □ No
s certii lirecto	o Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 X No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatie	l au	h <i>(Check only one)</i> ome 5 ☐ Residence	C □0ther (Creek	
: After this s funeral d	ition: To	27. Manner of Death  1 X Natural 5 Pending 2 Accident investigation  28a. Date of Injury (Month, Day Year) Injury		28d. Describe how in		<u>19)</u>
al Directo ed in by th	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, s building, etc. (Specify)	treet, factory, office	28f. Location (Street City or Town, Sta	and Number or Run ate)	al Route Number,
he Funera pietely fille	Medical (	29a. Certiflier (Check only one)  1 Certifying Physician: To the best of my knowledge, dea 2 Medical Examiner: On the basis of examination and/or and manner stated.	th occurred at the time, date and place, nvestigation, in my opinion, death occur	and due to the cause red at the time, date a	e(s) and manner as s and place, and due t	stated. to the cause(s)
Tot	Σ	29b. Signature and title of certifier  Adman	TOR D19609.		CTOBER 3,	
K		30. Name and address of person who completed cause of death (Item 23a) (Type DR. RAMAN R. TULI, 10810 DARNESTOW		GAITHERSB	URG, MD	20878
Sta Registr	_	31. Date filed (Month, Day, Year)  OCT 0 9 2007				

DHMH 17 Rev 1/2001

	4	For State		partment of Health and N		21111	32282
		Registrar  1. Decedent's Name (First, Middle Las		ertificate of Death	Reg. N	10.2001	3. Time of Death
. Physicia /Medic	n	Annie Ru	ith Thornt	700	Month C	2007	0630 A M
Examine		4a. Facility Name (If not institution, give	street and number)	4b. City, Town, or Location of Death	7	c. County of Death	
Funeral		5. Social Security Number 6. So	ex 7. Age (In yrs. last birthda	y) If Under 1 Year If Under 24 Hrs.	8. Date of Birth (Month, Day, Yea	r) Coun	ace (State or Foreign (ry)
Director	-	Usual Residence of Decedent			9-19-		rginia
larylan show	.	10a. State 10b. County	10c. City, Town or			11	0d. Inside City Limits  1   Yes 2 No
death with the Maryland ms 23a or 28a-f show r must be notified at	Director	10e. Street and Number 7424	W.Belvedere Au	Himore 10f. Zip Code	10g. (	Citizen of What Coun	try?
th with 23a or 1st be	a	Levindale N	lusing Home	21215		USA	
er dea Items	Funeral	11. Marital Status 1 □ Never Married 2 □ Married	12. Was Decedent Ever in U.S. Armed Forces?	<ol> <li>Was Decedent of Hispanic Origin? (Sparse) If Yes, specify Cuban, Mexican, Puert</li> </ol>	pecify Yes or No- o Rican, etc.)	14. Race - America Black, White,	
J.S. a. Irs a sur, o su	þ	Widowed 4 □ Divorced	1	1 ☐ Yes 2 ☑ No Specify:		Specify: Blo	ack
72 ho 72 ho "natur edical	Completed	15. Decedent's Ed (Specify only highest gra	de completed) (G.	cedent's Usual Occupation ive kind of work done during most of wor a. DO NOT use retired)		Kind of Business/Inc	lustry
within 72 rene.	ошо	Elementary Secondary (0-12)	College (1-4or 5+)	Cook	7	estau	rant
and 21215-0-0 d be filed within 72 ho ental Hygiene. ed other than "natu	Be	17. Father's Name (First, Middle, Last)	_	18. Mother's Nan	ne (First, Middle, Maid	en Surname)	
유 등 등 등 등	၉	19a, Informant's Name/Relationship	Time Print) 19h M	ailing Address (Street and Number or Ru	1) e De	Zan State Zie	Cadal
Md 2 md 2 md 2 md 2 md 2 md 2 md 2 md 2		Annie. B. Har	is (Daughter) 131	5 Chesaco Ave	4 -1 -5 -1	Rado.m	D 2/237
altimore, Imit. Pages 1 an partment of Healt portant: If Item 2 y Injury or other 66.	-	20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐	20b. Place of Discemetery, of	sposition (Name of crematory or other place)	Date 20c.	Location - City or To	wn, State
Limo		4 Donation 5 Dother (Specifi	Gamiso	N Forest Cemeders 16	0/12/01 C	WINGSK	Iills, MD
baltim permit. Par Departmen Important: any Injury.		21. Signature of Funeral Service Licer	1 M00944		tuiral s	Services Sto MID	2122 11
		23a. Part1. Enter the disease, of company of heart failure. List only	plications that caused the death. Do not one cause on each line.	enter the mode of dying, such as cardiac	or respiratory arrest,	Me Mi	Approximate Interval Between
Physician	1	Immediate Cause (Final disease or condition	Acute My	rocardial Infa	retion		Onset and Death
/Medical Examiner		resulting in death)	Due to (or as a consequence or :				
	Jer	Sequentially list conditions, if any hand go in mundrat cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to for as a consequence of				
60, be executed ician and burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c				
E E E		resuming in assum, East	Due to (or as a consequence of):				
687 tificate g physi as the l	ledical		d				
I HECOTGS, P.O. BOX 6  The law requires that the death certific  ate has been signed by the attending page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death	3 □Ectopic pregnancy		23d. Date of delive	ery Day Year
the dea	ysici	1 Yes 2 No	4□Pregnant at time of death 9□Unknown	5 Other (specify)		World	Day Tour
cords, P.O. w requires that the deben signed by the should be detached	by Ph	Part II. Other significant conditions	contributing to death but not resulting in th	e underlying cause given in Part I.	23e. Did tobacc	co use contribute to the	ne cause of death?
ould b					1 ☐ Yes	2 No 3 Prob	ably 4 Unknown
al Reco	Completed				24a. Was an autopsy	. prior to co	psy findings available mpletion of cause of
Vital Records, P. stcian: The law requires that certificate has been signed b. rector, page 2 should be deta		25. Was case referred to medical		26 Place of Do	performed  1 Yes 2 D  ath (Check only one)	No 1 ☐ Yes	2 No
r VI nyslcia nis cert direct	To Be	examinar? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpa	Othor	lome 5 ☐ Residence	e 6 ☐Other (Special	ý)
DIVISION OF  I or Attending Phys after death.  Director: After this in by the funeral dir		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury 28b. Tim (Month, Day Year) Inju	ry Work?	28d. Describe how in	njury occurred	
ISIO Nttend death. ctor: / y the f	icati	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	e 290 Place of injury - At home form	M 1 Yes 2 No	28f. Location (Street	t and Number or Rura	al Route Number.
DIV safter al Dire	Certification:	4 ☐ Homicide determined	building, etc. (Specify)	•	City or Town, Si		
DIVISION OF VITAI To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, p	ca	(Check only 2 Medical Example 12 Medical Example 2 Medical Example 12	nysician: To the best of my knowledge, d miner: On the basis of examination and/o and manner stated.	r investigation, in my opinion, death occ	urred at the time, date	and place, and due t	o the cause(s)
To the within To the comple	Me	29b. Signature and title of certifier	and the state of	29c. License number	29d.	Date signed (Month,	Day, Year)
9		> Zeeleng Per	n	D50693		oct 3,	2007
3		30. Name and address of person who Alcun h. Pe	and manner stated.  completed cause of death (Item 23a) (Ty  plus, MD Sine  3. Registrar's Signature	pe, Print) Hospital of	Buchiner	1	
			1 /				
Sta Registr	te	31. Date filed (Month, Day, Year)	32. Registrar's Signature				

20b. Place of Disposition (Name of cemetery, crematory or other place)

Parkwood Cemetery

Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line.

Evere

Due to (or as a consequence of):

18821 Foreston Road, Hampstead, Maryland 21074

Eckhardt Funeral Chapel, P.A. 3296 Charmil Drive, Reisterstown, Maryland 21102

Oct.

2007

Sevile demential Alleremers The

20c. Location - City or Town, State

23d. Date of delivery

05) 2007

Day

3 Probably 4 Unknown

24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No

Baltimore, Maryland

200mm

Year

death with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan. Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. Baltimore, Maryland 21215-0036

Physician

/Medical

Examiner

Funeral Director

2

Completed

Be

ျှ

Richard L. Trimble, Jr.

4 □ Donation 5 □ Other (Specify)

ignature of Fune A Service Lic

3 ☐ Removal from State

20a. Method of Disposition

Immedia e Cause (Final diseas or condition resulting in death)

XX Burial 2 Cree

**Funeral** 

Director

**Physician** /Medical **Examiner** 

physician ed by the a detached f certificate this funeral Aftert

the Hospital or Attending Physician: The law requires that the death certificate be executed hours after dea h. within 24 hours after death To the Funeral Director completely filled in by the

Division or Vital Records, P.O. Box 68760,

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off Examine Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by hriae 2 No 1 Tyes 24a. Was an autopsy perform 1☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 2 No Certification: To 1 ☐ Yes 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury 28c. Injury at Work? 5 ☐ Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 🚧 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D316(00 xclus inma Esm

State Registrar 31. Date filed (Month, Day, Year) 32. Refistrar's Signature DCT 0 9 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

GALVIN 291 STONER NEWE LUPS MINSTER 115

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. ASTATE of Maryland Department of Health and Wental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Traore 10:02 A M Moussa october 05 2007 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death SAINT AGNES HOSPITAL BALTIMORE If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 04 | 04 | 52 5. Social Security Number 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign **X**□M 2□F Months West Africa 219-04-9317 55 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Y∏Yes 2 ☐ No Baltimore NA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21223 U.S.A. 2523 Edmondson Ave Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: Black 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Home Boy Fashion Owner 10th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Aisha Kouanda Ibrahim Traore 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 35 Odell Ave, Yonkers, NY 10701 Cheickna Maiga-Uncle 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) <del>Uk</del> Rikba Cemetery 10/14/07 Rikba, Burkina Faso 21. Signature of Funeral Service Licenses March fyff West 4300 Wabash Ave, Baltimore, Md 21215 23a. Part1/ Enter the disease, or complications that caus/ d the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resoluting in death) ASPIRATION PNEUMONIA 6 hours Due to (or as a consequence of): 6 hours HYPUxia Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 4□Pregnant at time of death 9□Unknown Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Multiple CVA 1 | Yes 2 | No 3 | Probably 4 | Jonknown Hypertension 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes P☐ No 24a. Was an autopsy performed Sarco dosis ₽ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

/Medical **Examiner** been signed by the attending physician and should be detached for use as the burial-tran-Records, P.O. Box 68760. Division or Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica

**Physician** 

/Medical

Examiner

10a. State

MD

**Funeral** 

Director

death with the Maryland

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.

**Physician** 

ģ

Be

Examiner

Physician/Medical

Completed by

Be

Certification:

Medical

29a. Certifier

(Check only

3altimore, Maryland 21215-0036

State Registrar

TaviN-M MD 29c. License number P- 19514 29d. Date signed (Month, Day, Year) October, 05, 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

TARIA MAHMOUD 900

caton

Baltimore, MD, 21229 Ave

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

OCT 0 9 2007



State of Maryland / Department of Health and Mental Hygien  $\geq 0.07$ 32285 1 - For Stete Registrer Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Lee Edward Tatum October 5, 2007 10:22 a<sup>M</sup> /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 2003 Starr Street Harford Edgewood Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs, last birthday) 5. Social Security Number 6. Sex **Funeral** Days Months Hours 1X M 2□ F 1935 Director 228-44-7375 Virginia Usual Residence of Decedent 10b. County 10c. City. Town or Location 10d. Inside City Limits 10a State or than "natural", or iteme 23a or 28a-f ehov the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Directo Maryland Harford Edgewood 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2003 Starr Street 21040 USA by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or ites ary or other treumatic event, the Mccical Examinal 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify. 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) State Government 6 Highway Worker 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be 2 William Upton Horner Sr. Julia Mae Whitlock 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2105 Morgan St., Edgewood, MD 21040 Donna Tatum / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2X Cremation 3 ☐ Removal from State permit. Page Department of Important: If eny injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Corp. 10-09-07 Towson, Maryland 21. Signature of 5 22. Name and Address of Facility
McComas Funeral Home, P.A. 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 1317 Cokesbury Rd., Abingdon, Maryland 21009 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Acute Infunition Mybehrdin + cond **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine physicien and s the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical ettending p for use as as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 2 Fetal death 3 Ectopic pregnancy Year Month Day 4☐ Pregnant at time of death 5 Other (specify) signed by the e Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Winknown should I 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? certificate has blirector, page 2 s 2□ No 1 ☐ Yes 1 Yes To the Hospital or Attending Physicien: director, Be 25. Was case referred to medical examiner? 26. Place of Death | Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No this After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification; 1 Natural 2 Accident 5 Pending investigation death. 1 ☐ Yes 2 ☐ No after death | Director: / d in by the f 28l. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 Could not be 28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) 4 Homicide within 24 hours aft To the Funeral DI completely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) North AVIANE 146JWH d 31. Date filed (Month, Day, Year) 32. Registrar's Signature State OCT 0 9 2007 Registrar

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** JOAM RETHA **TAYLOR** 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death Examiner That more !! laryland Genera 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Age (In yrs. last birthday) **Funeral** Days Hours 1 M 2 TF 243-24-4980 2-2-1920 Director NC Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 10a. State 10b. County 1 X Yes 2 ☐ No Director MD BALTIMORE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygene. Important: If item 27 is marked other than "natural", or Items 23a or: any Injury or other traumatic event, the Medical Examiner must be nonce. 821 SARATOGA STREET 21201 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black. White, etc. 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify Specify: Completed by 3 Widowed 4 Divorced BLACK 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) FACTORY WORKER **FACTORY** 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be JOHN WESLEY HINNANT ပ္ SARA 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) GERALDINE HINNANT/NIECE 635 N. FULTON AVE., BALTO., MD 21217 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3 □ Removal from State BALTO., MD 4 Donation 5 Dother (Specify) MT. ZION 10-12-07 21. Signature of Funeral Service Licensee 22. Name and Address of Facility JAMES A. MORTON & SONS F.H., INC. 1701-31 LAURENS ST. BALTIMORE, MD Approximate Interval Between Onset and Death 23a. Part1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician Yrovole disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner use as the burial-tran The law requires that the death certificate be exer Due to (or as a consequence of): physician attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 24a. Was an certificate has I rector, page 2 s autopsy performed? Yes 2 No funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 276 No Medical Certification: To 1 Impatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Natural Accident Year) Injury (Month, Ďay 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: completely filled in by the i 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only

P.O. Box 68760. Division or Vital Records. To the Hospital or Attending Physician:

altimore, Maryland 21215-0036

one)

29b. Signature and title of certifier

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. Registrar's Signature 31. Date filed (Month, Day, Year)

Saay



29c. License number

29d. Date signed (Month, Day, Year)

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Amend #7,8,perInf,0872, 10/16/07 TTCertificate of Death Reg. No. 2007 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Ethlyn Marie Tarr 3, 2007 1:58 P <sup>M</sup> October | /Medical 4a. Facility Name (If not institution, give street and number) 4b. Cify, Town, or Location of Death 4c. County of Death Examiner 4300 Newport Avenue Home; Baltimore N/A5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 5/11/1921 9. Birthplace (State or Foreign Country) **Funeral** 1 M XXF Months Days Hours 216-12-5890 Director 86 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits ns 23a or 28a-f show must be notified at Director Yes 2 □ No Maryland N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4300 Newport Avenue 21211 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes = 2**X2N**00 If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 ō þ 1 ☐ Yes 2 ☐ No ¥₩ Widowed 4 Divorced Specify: white "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) the Paper Hanger Self Employeed 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be 1 Department of Health and Mental Important: If Item 27 Is marked o any injury or other traumatic eve William Raymond McCauley Marie James 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William Tarr, Jr. Son #8 Belmullet Court #101 Lutherville, MD 21093 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State Moreland Memorial Park 4 ☐ Donation \_5 ☐ Other (Specify) 10/8/07 Parkville, Maryland 21. Signatural Suneral Service Lio-seed 22. Name and Address of Facility Burgee-Henss-Seitz Funeral Home, Inc. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ast only one cause on each line. 23a. Part1. Enter the disease shock, or heart failure. I Immediate Cause (Final disease or condition resulting in death) **Physician** CVA /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Gause [Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed attending physician and for use as the burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 ment 1 Yes 2 No 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy 1☐ Yes Hospital or Attending Physician: director 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 ☐ Accident 5 Pending investigation Injury 1 □ Yes 2 □ No ours after death.
neral Director: / 6 ☐ Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier Ceatifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of cortifier 29c. License number 29d. Date signed (Month, Day, Year) D 51715

Registrar

State

1440

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

373~

Registrar's Signature

Grunn,

31. Date filed (Month, Day, Year)

2007

NO

3 An (mone)

2/2/1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death October 6, 2007 2:45 p M Francis George Ugiansky 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 2012 Deering Avenue N/A Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Oct. 4, 1926 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 56¥ 1∐-M 2□F Days Months Hours Maryland 220-18-8295 81 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 □ No N/A MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2012 Deering Avenue 21230 United States 12. Was Decedent Ever in U.S. Are Are Forces? 1 2 Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No White Specify 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Metalurgist Metal 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) John Ugiansky Margaret Lugia 19a. Informant's Name/Relationship (Type. Print)
Ronald King - Son 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 109 Garfield Lane, Simpsonville, SC 29681 20b. Place of Disposition (Name of Clemetary competery or other place) Date 20c. Location - City or Town, State Method of Disposition HXBurial 2 □Cremation 3 □Removal from State 4 ☐ Conation 5 ☐ Other (Specify) 10-9-2007 | Glen Burnie, MD Memorial Park 22. Name and Address of Facility Ambrose Funeral Home, Inc. 21. Signature of Funeral Service 2719 Hammonds Fry Rd., Lansdowne, MD 21227 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ADDER ANCER years Due to (or as a consequence of) Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Monknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA ome 5 Residence 6 Other (Specify)
28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work?

**Physician** /Medical Examiner Examiner

**Physician** 

/Medical

**Examiner** 

Director

by Funeral

Be Completed

2

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at

Maryland 21215-0036

Baltimore,

Physician: The law requires that the death certificate be executed burial-transit and physician the as use for ed by the a signed t page 2 s has certificate I

Physician/Medical

Completed by

Be

မ

1 Natural

2 Accident

4 ☐ Homicide

3 ☐ Suicide

29a. Certifier

Certification:

Medical

this After Hospital or Attending within 24 hours after death.

To the Funeral Director: A completely filled in by the fu death.

Division or Vital Records, P.O. Box 68760,

31. Date filed (Month, Day, Year) State

5 Pending

investigation

6 Could not be determined

32. Registrar's Signature

D16354

1 ☐ Yes 2 ☐ No

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CATON AVE BALTIMORE MD 21229 900

OCT 0 9 2007

29b. Signature and title of certifier

Injury

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Baltimore, Maryland 21215-0036 OCTOBER 6, 2007 4:20 p.m.

85	
Division or Vital Records, P.O. Box 68760,	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

JOSEPH VERDERAMI

	1 - State Registrar	ryland / Depa	tificate of E		Reg	No. 2007						
sician	Decedent's Name (First, Middle, Last)				2. Date of Death Month	Day Year	3. Time of Death					
edical	Joseph S. Verderami  4a. Facility Name (If not institution, give street and number)		4b. City, Town, or I	ocation of Death	October	6, 2007 4c. County of Dea	4.20 F					
miner							imore					
ral	Stella Maris  5. Social Security Number 6. Sex 7. Age	(In yrs. last birthday)	If Under 1 Year	onium If Under 24 Hrs.	8. Date of Birth	9. Bir	thplace (State or Foreign					
tor	216-32-7072 1MM 2□F Usual Residence of Decedent	98 Yrs.	Months Days	Hours Min.	(Month, Day, Y) Feb. 5,	,	ryland					
	10a. State 10b. County	10c. City, Town or Lo	cation				10d. Inside City Limits 1 ☑ Yes 2 ☐ No					
Director	Maryland N/A		Baltimor	e	140	077	••					
븁	10e. Street and Number		10f. Zip Code		109	. Citizen of What Co						
Funeral	5439 Belair Road  11 Marital Status 12. Was Decedent E	Syoria II S 12 )	21200		soifu Vac or No	U. S.						
Ę	11. Marital Status  1 Never Married 2 Married  1 Never Married 2 Married  1 Yes 2 N		Was Decedent of His f Yes, specify Cubar	, Mexican, Puerto	Rican, etc.)	Black, Whit						
ķ	3 X Widowed 4 □ Divorced If Yes, Give Year or Dates:		1 □ Yes 2 🔯 No	Specify:		Specify:	White					
To Be Completed by Funeral Director	15. Decedent's Education (Specify only highest grade completed)	16a. Deced	dent's Usual Occupa kind of work done di DO NOT use retired)	tion uring most of worki	ng   16	b. Kind of Business	/Industry					
d W	Elementary/Secondary (0-12) College (1-4or 5-	+)	Barber			Barber	Shop					
Be C	17. Father's Name (First, Middle, Last)			18. Mother's Name	(First, Middle, Ma							
7 B	Simone Verderami			Rosa	Rinaldo							
	19a. Informant's Name/Relationship (Type. Print)	19b. Mailir	ng Address (Street a	nd Number or Rura	al Route Number, C	City or Town, State,	Zip Code)					
	Danielle Hildreth (Grandd					Maryland						
	20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State	20b. Place of Dispo cemetery, crer	sition (Name of natory or other place	<i>)</i>	Date 20	c. Location - City or	Town, State					
	4 Donation 5 Other (Specify)		edral Cem			altimore,						
once	21. Signature of Fuheral Service Licensee  22. Name and Address of Facility Schimunek Funeral Home Inc.  9705 Belair Rd., Nottingham, Maryland 21236											
	23a. Pr.rt1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, hock, or heart failure. List only one cause on each line.											
an cal	Immediate Cause (Final disease or condition resulting in death)  a.CONGESTIV		Onset and Death									
er er												
iner.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	a consequence of):										
dical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	a consequence of):										
		2 3011304001130 31).										
<u>a</u>												
pleted by Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 ☐ Fetal death 3 ☐	Ectopic pregnancy Other (specify)		·	23d. Date of de Month	elivery Day Year					
된		ut not resulting in the u	nderlying cause give	n in Part I.	23e. Did toba	cco use contribute t	to the cause of death?					
yd by					1 ☐ Yes	2 □ No 3 □ P	robably 4x Unknown					
Completed	1				24a. Was an	24b. Were a	utopsy findings available					
					autopsy performe 1∐ Yes 23	ed? death?	completion of cause of s 2 □ No					
e C	25. Was case referred to medical			26. Place of Death	(Check only one)							
To B	1 ☐ Yes 2 <b>K</b> No Hospital: 1 ☐ Inpatie	nt 2 ☐ ER/Outpatier		4 ☐ Nursing Ho	me 5 ☐ Residen	ce 6 XIOther (Spe	ecify) HOSPICE					
Ë	27. Manner of Death 1 ☑ Natural 5 □ Pending (Month, Day		Work		28d. Describe how	injury occurred						
catic	2 Accident investigation 3 Suicide 6 Could not be 289 Place of injure			es 2 □ No		<del>-</del>						
Certification:	4 Homicide determined 28e. Place of inju-	rry - At home, farm, str c. (Specify)	еет, тастогу, описе		City or Town,	et and Number or R State)	iurai Houte Number,					
ledical Certification: To Be Com	29a. Certifier (Check only one)  1  Certifying Physician: To the best of and manner sta	examination and/or in										
M	29b. Signature and title of certifier		29c. License	number 13725		1. Date signed (Mon	_					
	30. Name and address of person who completed cause of de											
State		LANEY VALL ar's Signature		TWONI OM,	MD 21093							
jistrar	OCT 0 9 2007	ar's Signature	parti									

DHMH 17 Rev 1/2001

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 12:10 PM Kobert 2007 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Baltimore Mercy Medical center 9. Birthplace (State or Foreign Country) Maryland 8. Date of Birth (Month, Day, Year) June 19,1936 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 M 2 □ F Months Days Hours 217-34-6340 71 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 □Yes 2 No Directo Maryland | Baltimore Dundalk 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8555 Kavanagh Road 21222 USA Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after content of health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item any injury or other traumatic event, the Medical once. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married 1 ☐ Yes 2X No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Retail 12 years 4 years Store Manager 18. Mother's Name (First, Middle, Maiden Surname) 17, Father's Name (First, Middle, Last) Be Bertha Frances Roberts John Michael Varholy ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 8555 Kavanagh Road, Dundalk, MAryland 21222 Marie Varholy wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition October 9 1X Burial 2 ☐ Cremation 3 ☐ Removal from State HOly Redeemer Baltimore, Maryland 2007 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, MD. 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure ust only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final abdominal sepsis dous **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): days perforation **Examiner** colonic Sequentially list conditions, Due to for as a consequence rany, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760 Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No the 9□Unknown 9 I Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ funeral director, page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Monknown carcinomo Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2. No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient Certification: To 27. Manner of Death 28a. Date of Injury 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred After (Month, Day Year) Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide

within 24 hours after death.

To the Funeral Director: A
completely filled in by the fi

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated.

29b. Signature and title of certifier

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

St. Paul Place Baltmore, Maryland 21202 31. Date filed (Month, Day, Year)

Registrar

Medical

OCT 0 9 2007



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 7-43A M 05 2007 UCTOBER orina /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMORE HOSPITAL SAINT AGNES If Under 1 Year | If Under 24 Hrs. 8. Date of Birth
(Month, Day, Year) 6. Sex Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days 1 □ M 2 🗙 F Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ortant: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show Injury or other traumatic event, the Medical Ex. miner must be notified at MD 1 XYes 2 □ No Director t more 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code 72 hours after death with Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) - American Indian 11 Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married 1 ☐ Yes 2 No Saltimore, Maryland 21215-0036 2 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during r life. DQ NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within. Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "ranged any Injury or other Presiments." College (1-4or 5+) Elementary/Secondary (0-12) rectiona 18. Mother's Name (First, Middle, Maiden Surname) 17 Fether's Name (First, Middle, Last) Be 19a Informant's Name/Relationship (Tv 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2122 Himore 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 □Removal from State 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Device Licenses Approximate Interval Between Onset and Death 23a. Part1. Enter the disease shock, or heart failure. sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ure. List only one cause on each line. Immediate Cause (Final Physician CONGESTIVE YEARS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner 2YEARS ARDIOMYOPATHY ISCHAEL NON Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner sate has been signed by the attending physician and page 2 should be detached for use as the burial-tran Due to (or as a consequence of): Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☒ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2X No certificate 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 1 🔀 Inpatient Certification: To ō this funeral ( 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred Injury at Work? After 1 Natural
2 Accident Division or Attending 5 Pending investigation (Month, Day Year) Injury 1 ☐ Yes 2 ☐ No the Director: 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours a To the Funeral L Hospital 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) E. Vishner Deepike MD 2007 OCTOBER 05,

Registrar DHMH 17 Rev 1/2001

State

-32. Redistrar's Signature

900

S. GATEN AVE,

BALTIMORE, MD - 21229

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

0

EVURI

VISHNU DEEPIKA

31. Date filed (Month, Day, Year)

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		-	State of Maryland / Department of Health and M  State of Maryland / Department of Health and M  Certificate of Death	emarr	Reg. No.		32292				
	Physicia	n	1. Decedent's Name (First, Middle, Last)	2. Date of D	eath 4 <sup>Day</sup>	200 <sup>y</sup> 7 <sup>ar</sup>	3. Time of Death 2:00p M				
	/Medic	al	William Elliott Wanken, Sr.  4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death	000.		County of Death	2.000				
	Examin	er	2401 Bachman Valley Rd. Manchester			Carroll					
	Funeral Director		5. Social Security Number  6. Sex  1 Age (In yrs. last birthday)  7. Age (In yrs. last birthday)  1 Under 1 Year   If Under 24 Hrs.    Months   Days   Hours   Min.    88   Yrs.	8. Date of E (Month, L Jan •	irth Pay, Year) 27,	9. Birthp Cour 9 Ma	olace (State or Foreign oryland				
	and w		Usual Residence of Decedent         10c. City, Town or Location           10a. State         10b. County         10c. City, Town or Location			1	0d. Inside City Limits				
	Maryl -f sho	tor	Maryland Carroll Manchester				1 □Yes 2 🛣No				
	h with the 23a or 28a st be noti	al Director	10e. Street and Number 10f. Zip Code 2401 Bachman Valley Rd. 21102		_	izen of What Coul	ntry?				
320	d within 72 hours after death with the Maryland jien. jien. rthan "natural", or items 23a or 28a-f show the Medical Examiner must be notified at	by Funeral	11. Marital Status  1 □ Never Married  1 □ Never Married  3 □ Warried  3 □ Warried  3 □ Warried  1 □ Never Married  1 □ Yes 2 □ No  If Yes, Give  Year or Date W W II	ecify Yes or N Rican, etc.)	lo-	14. Race - Americ Black, White, Specify: Wh					
215-0036	within 72 hou lene than "natura he Medical E	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)	ng		ind of Business/In					
7	filed wi Hygien other th	Co	8 Fork Lift Operator  17. Father's Name (First, Middle, Last) 18. Mother's Name	(First, Midd		ack & D	ecker				
a 10	be od o	o Be	The factor of th			Elliott					
Maryland	d 2 should be f th and Mental I 7 is marked oi traumatic eve	악	19a. Informant's Name/Relationship (Type. Print)  19b. Mailing Address (Street and Number or Rura								
_	d 2		Marian Dell - daughter 2401 Bachman Valley								
Baltimore,	S = = 0		4 Donation 5 Dother (Specify)  Baltimore National Cer		Ba	ocation - City or T	e, MD.				
pair	permit. Page Department of Important: If any Injury or once.		21. Signature of Funeral Service Licensee  22. Name and Address of Facility Ec]  3296 Charmil Dr.	Manc	hest						
68/60,	Physician /Medical Examiner bubblished street brund-itausit street brund	al Examiner	Immediate Cause (Final	disease or condition resulting in death)  a. Die to Africa a consequence of):  Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events  C							
F.O. Box 68/	eath certi attending for use a	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown		-	23d. Date of deliv Month	very Day Year				
	w requires that the d been signed by the should be detached	þ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.			/	the cause of death? bably 4 □Unknown				
Hecol	The law req ate has beer page 2 shou	Completed		p∈	as an itopsy informed? s 2 N	death?	opsy findings available ompletion of cause of				
Vita	ding Physician: The n. After this certificate hi funeral director, page	Be	25. Was case referred to medical examiner?  Hospital:								
0	Phys r this ral dir	2	27. Manner of Death  28a. Date of Injury  28b. Time of  28c. Injury at			6 □Other (Specury occurred	ify)				
Division or Vital Records,	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director. After this certifica completely filled in by the funeral director, p	Certification:	1 Matural 5 pending (Month, Day Year) Injury Work? 2 Accident investigation 3 Suicide 4 Homicide (Month, Day Year) Injury Work? 1 Yes 2 No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		n (Street a Town, Sta		ral Route Number,				
_	To the Hospital or Attenwithin 24 hours after death To the Funeral Director:	Medical Ce	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occur and manner stated.	and due to t rred at the tir	he cause( ne, date a	s) and manner as nd place, and due	stated. to the cause(s)				
	To the within To the comple	Me	29b. Signature and title of certifier  MD 29 689	E		ate signed (Month					
	5		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  H. J. De Pamphilis MD, 795 Cherry Tree Ct., Hai								
	St Regist	ate rar	31. Date filed (Month, Day, Year)  OCT 0 9 2007  32. Registrar's Signature								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien > 0.0732293 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 22 15M Month Day Year **Physician** Wonson 4a. Facility Name (If not institution, give street and number) 汉〇八子 /Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimere Cit Medical Ceville NIA Ylexay If Under 1 Year | If Under 24 Hrs. Year) 59 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Days Hours Min. 1 ☐ M 2X F Months 48 Director 03 215-78-7532 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits r 28a-f sh notified MD NA Baltimore 1 XYes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? a or ms 23a 1135 Tiffany Ct. 21201 U.S.A. Funeral "natural", or Items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married Married Baltimore, Maryland 21215-0036 1 ☐ Yes 🎗 ☐ No Specify: Specify: Black à 3 Widowed 4 Divorced Completed permit. Pages 1 and 2 should be filed within 72 hc Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natuany injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12th grade College (1-4or 5+) Housewife na Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Bertha Jones Clarence Wonson ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21218 Kevin Barnes-Son 1020 East 33nd Street, Baltimore, Md 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) King Memorial Park 10/1/07 Randallstown, md 21. Signature of Funeral Service Licen MATCH APPEN FWEST 4300 Wabash Ave, Baltimore, Md 21215 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** cardiac arryonmore /Medical Due to (or as a consequence of): Examiner per kalemi Sequentially list conditions, it is a list of the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to lot al. Examiner physician and the burial-transit requires that the death certificate be executed revia acure un Kna Due to (or as a consequence of) Box 68760, Physician/Medical acterem Rex as attending IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months?
1 Yes 2 No 4☐Pregnant at time of death Month 5 Other (specify) P.O. the 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed een pertension 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No The law certificate has autopsy perform 1☐ Yes Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 1 Yes 2 No Other: P 2 ER/Outpatient 3 DOA 4 Nursing Home this 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28c. Injury at Work? 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred After t Certification: or Attending (Month, Day Year) 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation death. Director: 2 Accident 6 Could not be determined 3∏ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide hours after vithin 24 hou.

\*\*he Funeral D Vertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) 29b. Signature a of certifier 29d. Date signed (Month, Day, Year)

State

Registrar

30. Name and address of

31. Date filed (Month, Day,

Scoti

Year)

DHMH 17 Rev 1/2001

28 4

MD

rson who completed cause of death (Item 23a) (Type, Print)

c Pherson

32. Registrar's Signature

DO040166

10/02/2007

Mercy Medical Courser 30151 Part Plate

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** Mary Frances Walter 2007 /Medical September 30, 3:04 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Gilchrist Center <u>Towson</u> <u>Baltimore</u> If Under 1 Year 8. Date of Birth (Month, Day, Year) 6/6/1933 9. Birthplace (State or Foreign Country) Maryland Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min 1 ☐ M 2 🕱 F Director 74 220-26-4838 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show edical Examiner must be notified at 1 ☐ Yes 2 ☑ No MD Howard Elkridge 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21075 USA 6500 Tufts Drive Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🕱 No Specify: Specify: þ 3 ☐ Widowed 4 ☑Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Trecor Labritories Executive Secretary is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be nent of Health and Mental Mary Alice Crown Elvery Matthew Berg 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Important: If item 27 is any Injury or other tra once. Catonsville, Maryland 21228 112 Delrey Avenue Mrs. Patricia L. Lanham 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State TDBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Loudon Park Cemetery 10/4/07 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Loudon Park Funeral Home 3620 Wilkens Ave. Baltimore, Maryland 21229 23a. Part1. Enter the disease, or commencations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or he fit failure. List only ne cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Heari Physician perator /Medical Due to (ar s a consequence of): Examiner mummina veejes Sequentially list conditions, if any, leading to in mediat cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner CANCER Therap certificate be executed consequences physician an s the burial-tr Due to (or as a consequence of): Physician/Medical attending p 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a d be detached f 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>Ş</u> 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ ₩0 24a Was an autopsy performed? res 2 No 1□ Yes furieral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? or Attending 1 Natural 5 Pending investigation in 24 hours enter the Funeral Director: Attendately filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a, Certifier and manner stated. 29b. Signature and title of conflicer 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (1 m 23a) (Type, Print) Charles St. Balto. Md Z. 204 GAMC 6701 N. 31. Date filed (Month, Day, Year)

OCT 0 32. **39** giştrar's Signature State 9 2007

ORIGINAL

Registrar

Baltimore, Maryland

Division or Vital Records, P.O.

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** ROBERT LEO WOODWARD **OCTOBER** 2007 9:34 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE 9. Birthplace (State or Foreign Country) 8111 HILLENDALE ROAD 5. Social Security Number 6. Sex PARKVTI LF. If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Days 1 ₹ M 2 □ F 86 2/22/1921 GEORGIA 415-04-4404 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 🕅 No Director MD BALTIMORE PARKVILLE 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 8111 HILLENDALE ROAD USA 14. Race - American Indian, 21234 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 📉 No If Yes, Give Year or Dates: 1 Never Married Married 1 ☐ Yes 2 No Specify: Specify: WHTTE Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry STEEL PRODUCTS Elementary/Secondary (0-12) College (1-4or 5+) FABRICATION WELDER 12TH GRADE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be CLEVE ALAN WOODWARD OCIE PENLAND ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) HELEN L. WOODWARD/WIFE 8111 HILLENDALE ROAD BALTIMORE, MD 21234 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) PARKWOOD CEMETERY 10/10/2007 | BALTIMORE, MD 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. 21. Signature of Funeral Service Licensee 8521 LOCH RAVEN BLVD. TOWSON, MD Approximate Interval Between Onset and Death Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory agrest Cardio Vascular disease Immediate Cause (Final tors disease or condition resulting in death) Due to (or as a consequence of): Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?

Physician /Medical Examiner

> burial-transit and

the as attending properties of the second se

physician

signed by the a

page 2 should

the Director:

filled in by

completely

Medical

State

29a. Certifier

within 24 hours a

The law requires that the death certificate be executed

Box 68760,

Division or Vital Records, P.O.

Hospital or Attending Physician:

the

**Funeral** 

Director

iral", or items 23a or 28a-f show Examiner must be notified at

"natural",

th and Mental Hygiene.
7 is marked other than "natur traumatic event, the Medical.

Health a

Department of Healt Important: If item 2 any injury or other once.

Pages 1 and 2 should be filed within 72 hours after death with

Baltimore, Maryland 21215-0036

Examine Physician/Medical þ Completed Be Certification: To

2 No 3 Probably 4 Unknown 1 🗌 Yes 24a. Was an autopsy perform 1∐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 28b. Time of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural Accident Watural 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

27. Manner of Death

Texacertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier

29d. Date signed (Month, Day, Year)

24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) goucher

31. Date filed (Month, Day, OCT 0 9

eva 32 Registrar's Signatur The State of

and manner stated.

Registrar

Towson

Please	Type or Prin	t in Black I	ndelible lnk	Ensure Al	I Copies	Are Legible.		
For State Registrar	71	ryland / De	partment of F	Health and M	Mental Hyg	_	32296	
Registrar     Decedent's Name (First, Middle, La.	st)				2. Date of Deat	h	3. Time of Death	
Hanna		Wachte	er		October		10:35 P <sup>M</sup>	
4a. Facility Name (If not institution, giv			4b. City, Town, o	or Location of Death		4c. County of Death	'n	
Oak Crest Care				kville		Baltimo		
5. Social Security Number 6. S 214-14-8620		(In yrs. last birthda 87 Yrs.	Months Davs	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, April 2	Year) Cor	hplace (State or Foreign untry) aryland	
Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or	Location				10d. Inside City Limits	
		Baltir					1 XYes 2 No	
Maryland N/A  10e, Street and Number		Dailii	10f. Zip Code		1	0g. Citizen of What Co	untry?	
10e. Street and Number	Street		212	30		U.S.A.		
11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.S. 1	3. Was Decedent of H If Yes, specify Cub	Hispanic Origin? (Sp	ecify Yes or No-	14. Race - Amer Black, White		
1 ☐ Never Married 2 ☐ Married	1 ☐ Yes 2 📉 N		1 ☐ Yes 2 💢 No			Specific		
3 ☐ Widowed 4 ☐ Divorced	Year or Dates:		1 1 1 es 2 K 1 1 0	ороспу.		эреспу: W	hite	
15. Decedent's E (Specify only highest gr	ade completed)	(G	ecedent's Usual Occup live kind of work done e. DO NOT use retire	pation during most of work d)	ding	16b. Kind of Business/	Industry	
Elementary/Secondary (0-12)	College (1-4or 5-	+)	Homemaker		Own Home	Own Home		
17. Father's Name (First, Middle, Last	)			18. Mother's Nam	e (First, Middle, I	Maiden Surname)		
Charles	Lee P	lummer,	Sr.	E	thel	Sunderland	d	
19a. Informant's Name/Relationship				t and Number or Rui	ral Route Number	r, City or Town, State, 2	?ip Code)	
Charles M. Plum	mer Nephe	w 10:	27 W. Barr	e_Street	Baltim	nore, Maryla	and 21230	
20a. Method of Disposition		20h Place of Di	sposition (Name of crematory or other pla			20c. Location - City or		
1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other ( <i>Speci</i>	JRemoval from State fy)		Service C		2-2007	Towson M	aryland	
21. Signal of Funeral Gervice Lice		-	22. Name and Addre	ess of Facility Ru	ick Towso	n Funeral		
town tago			1050 Yor			Maryland 2		
23a. Part1. Enter the disease, or con shock, or heart failure. List only	nplications that caused one cause on each lin	the death. Do not e.	enter the mode of dy	ing, such as cardiac	or respiratory arr	est,	Approximate Interval Between Onset and Death	
Immediate Cause (Final disease or condition	a. A 5	CVD						
resulting in death)	Due to (or as	a consequence of):						
Sequentially list conditions, if any, leading to immediate	b	a consequence of):						
Cause (Disease or injury								
that initiated events resulting in death) Last	C. Due to (or as a	a consequence of):	****					
	d							
IE EENAL P.	_							
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 M No 9 □ Unknown	23c. If yes, outcome 1 □Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death	3 ☐ Ectopic pregnand 5 ☐ Other (specify) _	су		23d. Date of del Month	livery Day Year	
Part II. Other significant conditions	contributing to death bu	ut not resulting in th	e underlying cause gi	ven in Part I.	23e. Did to	bacco use contribute to	the cause of death?	
_					1 □ Y	′es 2 <b>∑√</b> 10 3⊟Pi	robably 4  Unknown	
- valvilar Chronic	obstruct	ive lu	ong dise	ease	24a. Was a autop perfor	sy prior to rmed? death?	utopsy findings available completion of cause of	
25. Was case referred to medical				26 Place of Dea	ath (Check only or			

Be Completed by Physician/Medical Part II. Othe

Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burlat-transit Medical Certification: To

 $\subset$ 

3 ☐ Suicide 4 ☐ Homicide

29b. Signature and title of certifier

29a. Certifier (Check only one)

1 - For State Registra 1. Decedent

**Physician** /Medical

**Examiner** 

**Funeral** Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at

**Physician** /Medical Examiner Be Completed by Funeral Director

P

25. Was case referred examiner?
1 Yes 2 No 27. Manner of Death 1 Natural 2 Accident

5 ☐ Pending investigation 6 ☐ Could not be

Hospital: 28a. Date of Injury (Month, Day Year)

1 Inpatient 2 ER/Outpatient 3 DOA

28b. Time of Injury

28c. Injury at Work? 1 ☐ Yes 2 ☐ No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Boolevard Parkville, MD 21234

D58646

2007

Mos Anna 31. Date filed (Month, Day, Year) State

32./Registrar's Signature OCT 0 9 2007

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Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 2007 Par 10:25p M 0ďťďber **Physician** Conway В. Weaver /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Towson 501 Hillen Rd. 8. Date of Birth (Month, Day, Y 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Year) 926 **Funeral** Min. Months Days Hours Pennsylvania 1**X** M 2□ F 80 162-22-1306 Director Usual Residence of Decedent should be filed within 72 hours after death with the Maryland and Mental Hyglene. So marked other than "natural", or items 23a or 28a-f show so marked other than "natural", or utems 24a or 28a-f show umafic event, the Medical Examiner must be notified at umafic event, the Medical Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 1 ☐ Yes 2 No Towson Md. Baltimore Director 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number USA 21286 501 Hillen Rd. Funeral 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1X Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2XX No Specify: Specify: White Completed by 3 Widowed 4 □ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life\_DO NOT use retired)
Clerical Elementary/Secondary (0-12) Baltimore City College (1-4or 5+) permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygie Important: If item 27 is marked other ti any injury or other traumatic event, the 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Helen Barton Clinton Weaver ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1012 Adcock Rd. Lutherville, Md. 21093 Mr. Edward Bond/ Friend 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐Removal from State Hilltop Service Co. 10-9-07 Towson, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature Funeral Service License <sup>22. Name and Address of Facility</sup> Funeral Home, RUCK TOWSON Funeral Home, 1050 York Rd. Towson, Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CAD HOUVS Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Atherusclerosis YEARS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner law requires that the death certificate be executed the burial-transi Due to (or as a consequence of) physician Physician/Medical attending ph for use as t IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2 □ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) ed by the a 9☐Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Dementia 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown zheimer Completed peen 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy has page 2 Itypercho lestero lemia certificate 1□ Yes 2 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 2**X**No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 □Other (Specify) 1 ☐ Yes ို After this funeral 28d. Describe how injury occurred 27. Manner of Death 1 Natural 2 Accident 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: Hospital or Attending Injury 5 ☐ Pending investigation in 24 hours area. the Funeral Director: After an Interest of the funeral in by the funeral filled in by the funeral fu 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 Homicide

To th. within 2.

Division or Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

State Registrar

Medical

31. Date filed (Month, Day, Year)

29b. Signature and the of certifier

ungue hah

OCT 0 9 2007

29a. Certifier



30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Eugene A. Obah, MD. 6565 N. Charles Street, Balto MD 21204

📂 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

D0044018 Oct. 08. 2007

## Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 32298 Certificate of Death 3. Time of Death 2. Dete of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** October 5, 2007 4:41 p.m. Della Victoria Walker /Medical 4b. City, Town, or Location of Death 4a Fecility Name (If not institution, give street end number) Examiner Rockville Montgomery Brighton Gardens If Under 1 Year If Under 24 Hrs. Birthplace (Stete or Foreign Country) 8. Date of Birth (Month, Dey, Yeer, 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 □ M 2 🖾 F Yrs. 27, 1922 Maryland June 85 219-12-4485 Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a. Stete 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours efter death with the Marylar Department of Heelth and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Itema 23a or 28a-f ahow any Injury or other traumatic event, the Medical Examiner must be notified at 1⊠ Yes 2 No Garrett Park Directo Maryland | Montgomery 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? United States 20896 4700 Oxford Street Funeral 14. Race - American Indian, 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11, Maritel Status Black, White, etc. 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White \$ 3 ☑ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 12 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Emma Johnson William J. Dove 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) J. Dianne Broadhurst / Daughter 1798 Myerly Lane, Detour, Maryland 21757 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Oct. Date 10. Parklawn Memorial 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Rockville, Maryland 4 ☐ Donation 5 ☑ Other (Specify) Entombment 2007 Park Mausoleum 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Rockville, Inc. 21. Signature of Funeral Pervice Lib 300 W. Montgomery Ave., Rockville, MD 20850 M00896 disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, failure. List only one cause on each line. Approximate Interval Between Onset and Death Enter the **Physician** Immediate Cause (Final disease or condition resulting in deeth) /Medical minutes Miocardial Infarction Examiner Due to (or as a consequence of) Physician/Medical Examiner anding physician and use es the burial-trensit requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to for as a consequence of Division of Vital Records, P.O. Box 68760 Due to (or as a consequence of): resulting in death) Last attending a signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Diabetes Mellitus Completed by page 2 should be 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Was en autopsy performed? peeu hes 1 ☐ Yes 2 🖾 No 1 ☐ Yes 2 ☐ No al or Attending Physician: The safter death.
I Director: After this certificet Be 25. Wes case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☑ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 1 ☐ Yes 2 No 28c. Injury at Work? 28d. Describe how injury occurred Certification: 27. Manner of Death 28b. Time of 1 XNatural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 28f. Location (Street end Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 ☐ Homicide To the Hospital within 24 hours a To the Funeral the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the ceuse(s) and menner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier edical (Check only one) 29d. Date signed (Month, Day, Year) Ccto Ser 5 2007 29c. License number 10 3 3 3 5 7 29b. Signeture and title of certifier men 10 30. Name end address of person who completed cause of death (Item 23e) (Type, Print) Lee Jonathan Musher, M.D., 5530 Wisconsin Ave. #1045, Chevy Chase, MD 20815
31. Date filed (Month (Month) Per Per 9 2007 32. Registrer's Signature

State

Registrar

31. Date filed (Month (Nay, Yes)) 9 2007

**DHMH 16 Rev 6/95** 

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Dav Physician October 4, 2007 3:00 A M Yetta F. Weisz /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Prince George's Mitchellville Collington Life Care Community If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** 1 □ M 2 😿 F Yrs. 91 New York May 6, 1916 Director 217-44-3810 Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 No r 28a-f sh notified Director Maryland Prince George's Mitchellville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with i Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 1 and highly or other traumatic event, the Medical Examiner must be a once. 10450 Lottsford Road Apt. 114 20721 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify: Specify: White 2 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) D.C. Public Schools School Teacher 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Samuel Faber Fanny Abrams 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6422 Bannockburn Drive, Bethesda, MD 20817 David F. Weisz/Son 20b. Place of Disposition (Name of cemetery, crematory or other place)
Montgomery
Crematorium, Inc. October 6. 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bethesda, Maryland 2007 M01346 | 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue Bethesda, Maryland 20814 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Arteriosclerotic Cardiovascular Disease /Medical Due to (or as a consequence of): Examiner Hypertension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine death certificate be executed Due to (or as a consequence of): burial-t Box 68760, attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 👿 No Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? or Vital Records, ģ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s has autopsy performed this certificate 2X No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Living Hospital: 1 ☐ Yes 2 😿 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending P within 24 hours after death.

To the Funeral Director: After t completely filled in by the funera After Certification: Division 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No M 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) October 5, 2007 D41945 ali & 20 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Cielito M. Aguinaldo, M.D. 1221 Mercantile Lane, Largo, MD 20774 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 1/2001

State

Registrar

OCT 0 9

2007

07-07387 John Williams Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

JOHN WIIIIAMS		1- For State Registrar	Maryland / Departmen Certificate			200°	7 3230
Physici Medical Exami		1. Decedent's Name (First, Middle,Last)	-		2. Date of Death Month	Day Year 21, 2007	3. Time of Death 1220 hrs
tu		John Williams  4a. Facility Name (if not institution, give s	reet and number)	4b. City, Town, or Location of Dea	September	4c. County of Death	1220 1113
		Johns Hopkins Bayview Med		Baltimore			_000
Funeral Director			7. Age (In yrs. last birthda	y) If Under 1 Year If Under 24H Months Days Hours M Yrs.		(MM/DD/YYYY) 9. Birth Foreign Cou	
way year	1000	Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or L	ocation			10d. Inside City Limits
laryland  8a-f show  at once.	o	MD	Baltim	nore			1 X Yes 2 No
with the Maryland ms 23a or 28a-f sho	Director	10e. Street and Number 905 Quantril Way		10f. Zip Code 21205	100	g. Citizen of What Count USA	ry?
hours after death natural", or ite	Completed by Funeral	1 Never Married 2 Married 3 Widowed 4 X Divorced If 1 15. Decedent's Education (Specify only I Elementary/Secondary (0-12)	Armed Forces?  X Yes 2 No res, Give Year Dates: highest grade completed)  College (1-4 or 5+)  16a. Deciduring	. Was Decedent of Hispanic Origin? ( If Yes, specify Cuban, Mexican, Puer  Yes 2 X No specify: edent's Usual Occupation (Give kind on most of working life. DO NOT use re	to Rican, etc.)		ack
-00, d withi giene. ther the	omi	17. Father's Name (First, Middle, Last)	0	18 Mother's Nan	ne (First, Middle, Ma	aiden Surname\	
21215-0036 buld be filed within 7 Mental Hygiene. marked other than c event, the Medica	Be	Sol Williams			Joan Cool		
e, MD 21215-0036  1 and 2 should be filed within 72  Health and Mental Hygiene, item 27 is mayked other than " r trainmatic event, the Medical.	10	19a. Informant's Name/Relationship (Type	1	ailing Address (Street and Number of			Zip Code)
nore, MD 2 ages 1 and 2 shou nt of Health and N it: If item 27 is n other traumatic	11,15	Nancy Aponte/frier 20a. Method of Disposition		Quantril Way Bal		ID 21205 20c. Location - City or T	own, State
nore		1 Burial 2 Cremation 3	Removal from State crematory of	or other place)	,		
Baltimore, permit, Pages 1 and Department of Heal Important: If iten injury or other tra	90-	4 Donation 5 X Other Specify: 21. La nature of Funeral Service Licensee R L L S	de, Director S	22. Name and Address of Facility tate Anatomy Boar	d 655 W.	Baltimore S	- Street
Physician		23a. Part I. Enter the disease, or complica failure. List only one cause on each	tions that caused the death. Do not en	Baltimore MD 212 ter the mode of dying, such as cardiac	O1 or respiratory arres	t, shock, or heart	Approximate Interval
/Medical "xaminer		Immediate see (Final disease a. N	arcotic intoxication  e to (or as a consequence of):				Between Onset and Death
	<u>ان</u>	Sequentially list conditions, if any, leading to immediate Due	e to (or as a consequence of):	No. of the last	*		
	Examiner	Course Chiter Underlying Cause (Disease or injury that initiated C				· 1.	
uted nd ransit		events resulting in death) Last Due d.	e to (or as a consequence of):				
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760, ficate be g physicisthe buri	/Me	IF FEMALE: 23b. Was decedent pregnant in the	33c. If yes, outcome of pregnancy			23d. Date of delivery	
that the death certificate by the attending process of the death of the attending process of the deached for use as the deached for use as the deached for use as the deached for use as the deached for use as the deached for the deached fo	Physician/I	past 12 months?	Live birth 2  Pregnant at time of death 5	Fetal death 3 Ectopic pregr Other (Specify)	nancy	Month Da	y Year
be dea	Phys		Unknown	be underlying any an in Dort I	220 Did tob	acco use contribute to the	a serve of death?
IS, P.O. puires that the series of signed by all the detact	ò		ntributing to death but not resulting in t	are underlying cause given in Part i.	1 Yes	2 No 3 Proba	bly 4 🗸 Unknown
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buri	Completed				24a. Was an autopsy perform	prior to co death?	psy findings available mpletion of cause of 2 No
Vital Rec ysician: The his certificate director, page	Be	25. Was case referred to medical examiner?	oital: 1 ✓ Inpatient 2 ER/Outpat	26.Place of Death (Check			=== 000
n of Vit ding Physic After this (	٩	1 ✓ Yes 2 No 27. Manner of Death	28a. Date of Injury (Month, Day, Year)  28b. Time		ing Home 5 R	esidence 6 Other:	
Sion Attendin death. ector: A	atior	Natural 5 Pending Accident Investigation	Fnd 9/17/2007 unk	1 Yes 2 X No	unk		
ivision  I or Attenc after death Director: d in by the	ertification	3 Suicide 6 X Could not be	28e. Place of Injury - At home, farm,	street, factory, office building, etc.	or Town, Sta	eet and Number or Rura	
Diviospital or hours after uneral Dir	아	4 Homicide determined  29a. Certifier (Check only)  1 Certifying Physician:	(Specify) found at home		905 Quan	tril Way Balti	
Divis  To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b	Medical	one) 2 Medical Examiner: On	To the best of my knowledge, death or the basis of examination and/or invest manner stated.				
E > E 8	₩	29b. Signature and title of certifier	C .	29c. License number		29d. Date signed (Monti	ı, Day, Year)
		Mot luoni	- Pollet an	O.C.M.E.		September 22, 20	)7
		<ol> <li>Name and address of person who com Patricia Aronica-Pollak MD.</li> </ol>	oleted cause of death (Item 23a) Assistant Medical Examiner	r 111 Penn Street, Baltimo	re, MD 21201		
	_	31. Date filed (Month, Day, Year)	32. Registrar's Signature	4			· · · · · · · · · · · · · · · · · · ·
Regist	rar	OCT 0 9 200	7 BENEVER ST PA	barle			

07-07433

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

James Weish		Stat - For State egistrar	e of Maryland <i>i</i>	Departmen Certificate			ental Hy		9. No. 200	7 32301
Physician Medical Examine	1	. Decedent's Name (First, Middle,L	ast)					2. Date of Death Month	Day Year 23, 2007	3. Time of Death 0000 hrs
Wedical Examine		James Welsh  Ha. Facility Name (if not institution, or	give street and number)		4b. City, T	own, or Locat	tion of Death	September	4c. County of Dea	
		Franklin Square Hospita			Rose			100	Baltimore Co	
Funeral Director		220-86-3452	Sex 7. Age  XM 2 F	e (In yrs. last birthda 44	y) If Unde Months		Under 24Hrs. lours Min.		(MM/DD/YYYY) g. E. Fore	
		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or L	ocation					10d. Inside City Limits
nd show a	_	MD Baltin	nore	Es	sex					1 Yes 2 X No
the Maryland a or 28a-f strow	Director	Oe. Street and Number 700 Manfield Roa	ad	40.00	10f. Zip	Code . 21221	- 2	10	g. Citizen of What Co USA	untry?
MD 21215-0036 2 should be filed within 72 hours after death with the Maryland hand Mental Hygiene. 27 is marked other than "naturial", or items 23a or 28a-f shountic event, the Medical Examiner must be notified at once	by Funeral		ed If Yes, Give Year or Dates:	X No	If Yes, specif	y Cuban, Mex	kican, Puerto I ecify:	eff)	White, etc.	ite
imore, MD 21215-0036  Pages 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene. It item 27 is marked other than "matural", or other traumatic event, the Medical Examiner.	Сошріете	15. Decedent's Education (Specify Elementary/Secondary (0-12)	College (1-4 or	5+) duri	edent's Usual ng most of wor ntracti	king life. DO I			16b Kind of Busines:  home impr	- mi-sec
Baltimore, MD 21215-0036 pemit. Pages I and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If tiem 27 is marked other than injury or other traumatic event, the Medical To De Comments.	De Con	17. Father's Name (First, Middle, La		, ,		ink 18.M	other's Name	(First, Middle, M	laiden Surname)	unk
D 21 should. nd Mer is man atic ev		9a. Informant's Name/Relationship		100	-	`			ber, City or Town, Sta	ite, Zip Code)
and 2 seatth a tem 27 traum	-	Peggy Welsh/spo 20a. Method of Disposition	ouse	20b. Place of D	sposition (Nar	ne of cemeter		sex, MD	21221 20c. Location - City	or Town, State
altimore, mit. Pages I an epartment of Hea oportant: If ite		1 Burial 2 Cremation		"cL	or other place)		10/10	9/2007	Balto. MD.	
altin mit. P partme portan ury or	1	Donation 5 X Other Special Service Lic Ronald S	ensee						neral Hore.	e Street
m ឱ្យដី គឺ ទើ Physician	1	ROHATO S 23a. Aart I. Enter the disease, of co	1 XXXX	JI/S	07.01d.1	astem <sub>M</sub>	Avenue 2	Essex, M	21221	Approximate Interval
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ox 687 eath certific attending p	<b>월</b>	F FEMALE: 3b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown	23c. If yes, outcor  1 Live birth  4 Pregnant at		Fetal death Other (Spe	3 E	ctopic pregna	ncy	23d. Date of deliv Month	ery Day Year
of Vital Records, P.O. B ing Physician: The law requires that the d. After this certificate has been signed by the tuneral director, page 2 should be detached.	≥	Part II. Other significant condition	ns contributing to deat	h but not resulting in	the underlying	g cause given	in Part I.		2 No 3 P	to the cause of death?  robably 4  Unknown  autopsy findings available
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irector	å a	25. Was case referred to medical examiner?	Hospital:	ent 2 🗸 ER/Outp		26.Place of D			Residence 6 Ott	her:
		1 ✓ Yes 2 No  27. Manner of Death  1 ✓ Natural 5 Pendin	28a. Date of Inju (Month, Day,)			28c. Injury at	Work?		now injury occurred	
Divisior ospital or Attend hours after death nneral Director: y filled in by the	Certification	2 Accident Investig 3 Suicide 6 Could r 4 Homicide	ot be 28e. Place of Ir	njury - At home, farm	street, factory	, office buildir	ng, etc.	28f. Location (S or Town, S		Rural Route Number, City
	agicai	one) 2 Medical Exami	sician: To the best of m ner:On the basis of exa and manner stated.	y knowledge, death mination and/or inve	stigation, in m	y opinion, dea	th occurred a	due to the caus t the time, date	and place, and due to	the cause(s)
		29b. Signature and title of certifier				c. License nui			29d. Date signed (# September 24,	
		30. Name and address of person was Ana Rubio MD. Assis	no completed cause of c tant Medical Exan		nn Street, I	Baltimore,	MD 21201			
Stat Registra		31. Date filed (Month, Day, Year)	32 Registra	ar's Signature	boule					

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			State of Maryland / Der 1- State Amend 4c, perMD, 10b, perFH, g872, 10/22	partment of Health and I	Mental Hyg	iene <sub>eg. No.</sub> 2007	32302
	Dhysisi	, y	Decedent's Name (First, Middle, Last)		2. Date of Deat		3. Time of Death
	Physici /Medic		Earl Charles Westph	al, Sr.		ember 26, 2007	8:30 a. M
	Examin	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	olomans	4c. County of Dea	th Calvert
		\$	Asbury-Solomans  5. Social Security Number 6. Sex 7. Age (In yrs. last birthda)				hplace (State or Foreign
	Funeral Director		220-18-7253 12 M 2 F 82 Yrs.	Months Days Hours Min.	(Month, Day,	7, 1925	Maryland
	ъ		Usual Residence of Decedent		IVIGION	17, 1020	
	show	5	10a. State   10b. County   Calvert   10c. City, Town or I				10d. Inside City Limits 1 ☐ Yes 2 🗖 🗖 o
	28a-f	Director	Maryland Prince Frderick  10e. Street and Number	Solomans  10f. Zip Code	1	Og. Citizen of What Co	
	3a or		11450 Asbury Circle Apt 200	20688		3	J.S.A.
	be filed within 72 hours after death with the Maryland Hylgiene. dother than "natural"; or ttems 23a or 28a-f show event, the Medical Examiner must be notified at	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13	. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert	pecify Yes or No-	14. Race - Ame Black, Whit	
ရွ	or it	by Fu	1 Never Married 2 Married 1 Myes 2 No WW11	1 ☐ Yes 2 No Specify:	7 110411, 010.7	Specify:	
- - - -	hour tural		CCHI	edent's Usual Occupation		16b. Kind of Business	White
<u>5</u>	in 72 in "na Medic	Completed	(Specify only highest grade completed) (Giv	e kind of work done during most of wor DO NOT use retired)	king	Tob. Nine of Edulitoson	
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	_ 0 0	Be	17. Father's Name (First, Middle, Last)	18. Mother's Nan		Maiden Surname)	i.a.a
		P	Charles Henry Westphal			eth Katherine Sp	
<u> </u>	d2 tha		19a. Informant's Name/Relationship (Type. Print)  Ms. Cynthia Salvo  Daughter	ling Address (Street and Number or Ru 17348 Whitaker Ct. St. In		•	zip Code)
ē,	permit. Pages 1 and Department of Health Important: If Item 27 any injury or other to once.		20a. Method of Disposition 20b. Place of Disposition	position (Name of ematory or other place)	Date	20c. Location - City or	Town, State
<u> </u>	Page: nent o nt: If i		I Burial 2   Cremation 3   Removal from State	ohn's Lutheran Church	10/01/07	Colu	mbia, MD
<u>n</u>	rmit. spartm porta y inju		21 Signature of Fyraral Service Licensee	22. Name and Address of Facility			
_	8 3 5 6 8	1	Seflurisden Alah New: 535	Slack Funeral Hor 3871 Old Columbi	a Pike Ellico		
			23a Part1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line.	nter the mode of dying, such as cardiac	or respiratory arr	est,	Approximate Interval Between Onset and Death
	Physician   /Medical		If mediate Cause (Final Assass or condition resulting in death)	AS SEPSIJ			2 WEEKS
	Examiner		Due to (or as a consequence of):	=LOID LEUK	FM.A		5 Y FARS
H		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	2013 120			3 ) ( ) ( )
	cuted nd ransit	Examiner	that initiated events C.				
Š,	e exe		resulting in death) Last Due to (or as a consequence of):				
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X	certifi Iding I Ise as	Physician/Me	IF FEMALE: 23c. If yes, outcome pf pregnancy			23d. Date of de	livon
DOX	The law requires that the death ate has been signed by the atter page 2 should be detached for u	ciar	in the past 12 months?	☐Ectopic pregnancy ☐ Other (specify)		Month Month	Day Year
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'n	es tha gned se det	by P	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tol	bacco use contribute to	
ecords,	requir sen si rould l	ted			1 🗆 Y	es 2 ⊒HNO 3 □ P	robably 4 Unknown
Ž Ž	has be	Completed			24a. Was a autops	24b. Were at	utopsy findings available completion of cause of
	n: The icate l				perform 1□ Yes	med? death? 2☐No 1☐Yes	2 □ No
VII	siciar s certif irecto	Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient	l Others	th (Check only on	*	
5	g Phy er this eral d	n: To	27. Manner of Death 28a. Date of Injury 28b. Time	of 28c. Injury at		ence 6 Other (Spe	City)
5	ath. ir: Aft	atio	1 ☑ Natural 5 ☐ Pending (Month, Day Year) Injury 2 ☐ Accident investigation	M 1 Yes 2 No		•	
2 2 2	ir Atte	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	treet, factory, office	28f. Location (St City or Town	treet and Number or R. n, State)	ural Route Number,
2	oitai o urs afi eral D						
	Hosp 24 ho Fund etely f	Medical	29a. Certifier  (Check only one)  1 ☐ Geffifying Physician: To the best of my knowledge, dea (Check only one)  2 ☐ Medical Examiner: On the basis of examination and/or and manner stated.				
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  Or the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Me	29b. Signature and title of certifier	29c. License number	2	9d. Date signed (Mon	'h, Day, Year)
}			I ( ff H Aloil m	026358		5F.PT. 2	6.2007
1 4	T		30. Name and address of person who completed cause of death (Item 23a) (Type	e, Print)			
1	0		31 Date filled (Month Day Mont) 200 Beginter's Signature	nd- PRINCE	1-REDE	RICKIN	1)-20678
	Sta Registr		31. Date filed (Month, Day, Year)  OCT 0 9 2007	p, Print)  p ) - PRINCE			

DHMH 17 Rev 1/2001

Registrar

MENIA

Registrar

DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day)

Day; Year)

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland PoerFH G872 of Health and Wental Hygiene Certificate of Death Reg. No. 2007 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) **Physician** Boddie 0600 AM Clinton October 2007 /Medical 4b. City, Town, or Location of Death Baltimere C 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Hopkins The Johns NIA Hospital If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country)
NORTH CAROLINA 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Months 2/7-38-5662 Usual Residence of Decedent 1⊠M 2□ F 66 Yrs. Director 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Pages 1 and 2 should be filed within 72 hours after death with the Marylan nent of Heatth and Mental Hygiene. ant: If Item 27 is marked other than "natural", or Items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at 1 XYes 2 No Directo MARYLAND 10g. Citizen of What Country? 10e. Street and Number USA Funeral Race - American Indian. Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 Married 1 Yes 25 No If Yes, Give Year or Dates: 3altimore, Maryland 21215-0036 1 Yes 2 No Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) OFERATOR MANUFACTURING 11+4GRADE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be LLIE ၀ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number of Bural Route Number, City or Town, State, Zip Code) STEPHANIE C. 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If ite
any injury or ot 1 Burial 2 □ Cremation 3 □ Removal from State BALTIMORE HARYLAND N JR. FUNERAL HOME 4 Donation 5 ☐ Other (Specify) 21. Ignature of Funeral Service Licensee 23a a.r. Enter he disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, spock, or be in tailure. List only one cause on each line. Preumonia week **Physician** resulting in death) /Medical Due to (or as a consequence of): Examiner Multiples Ten Months Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical as the nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Por in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4□Pregnant at time of death 5 Other (specify) ed by the a 9☐Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 1 Tes 3 Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy performe es 2 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Hospital: Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tyes Certification: To After this 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 X Natural 2 ☐ Accident 1 ☐ Yes 2 ☐ No death. within 24 hours after death To the Funeral Director: filled in by the 6 ☐ Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Medical 29c. License number october 8, 2007 RES -000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) , 600 N. Wolfe Street, Bultimore Maryland MD, State Registrar

			1 - For State Registrar	State of Marylan		rtificate of D			Reg. No 2	07	32306
99	Physici		1. Decedent's Name (First, Middle, Las	SROWN				2. Date of De Month	Dav	Year	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give			4b. City, Town, or I	Location of Death	10	4c. County		
			No RTHWEST	HOSPITAL		RANG	MISTON	12	BA	LTIMO	RE
22.	Funeral		Social Security Number     6. Security Number	ex 7. Age (In yrs. i		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da			ice (State or Foreign
L	Director		213-20-2002	<sup>□ M</sup> 2√ F 71	Yrs.			2-28-			MD
	and		Usual Residence of Decedent  10a. State 10b. County	10c. City	y, Town or Lo	cation				10	d. Inside City Limits
	Maryl f sho ied a	ō	MD N/A	В	altim	ore					1 ☐ Yes 2 ☐ No
	72 hours after death with the Maryland 'natural', or items 23a or 28a-f show dical Examiner must be notified at	Completed by Funeral Director	10e. Street and Number			10f. Zip Code			10g. Citizen of	Mhat Countr	y?
	h with	교	601 Wynoak Ay	ZONIIO		2121	1 0		HC	73	
	deat ms 2	ner	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?	S. 13.	Was Decedent of His If Yes, specify Cubar	spanic Origin? (Sr	pecify Yes or No		e - America	
9	after or ite mine	Fu.	1 ☐ Never Married 2 ☐ Married	1 ☐ Yes 2 ☐ No . If Yes, Give X		1 ☐ Yes 2 ☐ No	Specify:	nican, etc.)		Afric	
303	ours Iral", Exa	d b	3 Widowed 4 ☐ Divorced	Year or Dates:						Amer	ican
5-	72 h "natu	ete	15. Decedent's Ed (Specify only highest gra		(Give	dent's Usual Occupa kind of work done du DO NOT use retired)	urina most of worl	king	16b. Kind of B	usiness/Indu	ıstry
121	within iene. than "	m d	Elementary/Secondary (0-12)	College (1-4or 5+)		sing Aic			Но	spita	al
d 2	filed Hygid Hyg Hyg Hyg Hyg Hyg Hyg Hyg Hyg Hyg Hyg		12th 17. Father's Name (First, Middle, Last)		Nul		18. Mother's Nam	e (First, Middle	l , Maiden Surnan	ne)	
an	ld be ental ked o ic eve	To Be	William Jef	ferson		۱,	Margare	t Johr	nson		
Maryland 21215-0036	should tnd Men marke	-	19a. Informant's Name/Relationship (7		19b. Mailii	ng Address (Street a				State, Zip (	Code)
	and 2 saith a n 27 is ier trai		_Ida Dail/Da	ughter	2727	7 Hugo A	ve, Bal	timore	e, MD	21218	8
ore	es 1 a of He fiterr		20a. Method of Disposition 1 → Burial 2 ☐ Cremation 3 ☐	20b. P	lace of Dispo	osition (Name of matory or other place	i	Date	20c. Location	City or Tow	vn, State
Ē	Pag ment ant: I ury o		4 Donation 5 Dother (Specify	/)Ark	outus	Mem Par	k 10/1	2/07	Arbutu	ıs, M	D
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Fineral Service Licen			2. Name and Address	Uar	ri P (	Close F	9779	рδ
	□ □ = @ O		23a. Part1. Enter the disease, or companies to the companies or part failure. List only			126 Bela	ir Rd,	Balt.	, MD 21	206	
			shock, or heart failure. List only	one cause on each line.	n. Do not em	ter trie mode or dying	, such as cardiac	or respiratory a	irrest,		Approximate Interval Between Onset and Death
i le	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. PANCR		LC CHI	VCER				
	Examiner			Due to (or as a consequence of the consequence of t		- bleed					
		Jer	Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (or as a consequence)		1.500					
8	cuted	Examiner	Cause (Disease or injury that initiated events	· CAI	>						
0,0	e exerian ar		resulting in death) Last	Due to (or as a consequent	uence of):						
68760,	tificate be executed g physician and as the burial-transit	edical		d							
	± pig ≡		IF FEMALE:	23c. If yes, outcome pf pregna	anou.						
Box	attenc for us	ian/	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d	Ideath 3	Ectopic pregnancy Other (specify)				te of deliver onth [	y Day Year
P.O.	the de	Physician/N	1 ☐ Yes 2 ☐ No 9 ☑ Dnknown	9☐Unknown	eam 5L						
	The law requires that the death cer tte has been signed by the attendin bage 2 should be detached for use	y Ph	Part II. Other significant conditions of	ontributing to death but not rest	ulting in the u	nderlying cause give	n in Part I.	23e. Did	tobacco use con	tribute to the	e cause of death?
Division or Vital Records,	quires n sigr ald be	d by						1 🗆	Yes 2□ No	3 ☐ Proba	ably 4/1\squarenterments
000	aw reas bee	Completed						24a. Was		Were autop	sy findings available
Ä	sician: The law s certificate has t irector, page 2 s	E O						auto perf 1∐ Yes	ormed?	death?	pletion of cause of No
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> >	Physician: this certificatel director, I	70 [	1  Yes 2 No	Hospital: 1x Inpatient 2	ER/Outpatier		4 LI Nursing H	ome 5 ☐ Res	idence 6 □Oth	ner (Specify)	)
ח	ing P		27. Manner of Death  1. ■ Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	Work'		28d. Describe	how injury occur	red	
Sio	Attending r death. ector: After by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not be		omo form at		∕es 2 □ No	00f Legation	(Ctract and Num	and of Burni	Davida Aliverbas
⋛	or A	rtifi	4 ☐ Homicide determined	28e. Place of injury - At he building, etc. (Specify		eet, factory, office			(Street and Numi wn, State)	oer or nurar	Houte Number,
_	To the Hospital or Attending Physician: The I within 24 hours after death.  To the Funeral Lirector: After this certificate ha completely filled in by the funeral director, page.		29a. Certifier Certifying Ph	ysician: To the best of my kno	wledge, deat	h occurred at the tim	ne, date and place	, and due to the	cause(s) and m	anner as sta	ated.
	e Ho: e Fur letely	Medical		niner: On the basis of examina and manner stated.							
	To the within 2 To the Comple	Me	29b. Signature and title of certifier			29c. License	number		29d. Date signe	ed (Month, E	Day, Year)
			100	. MD		Do	06635	7	10/06	1200	7
	5		30. Name and address of person who	completed cause of death (Item	n 23a) (Type,					100	*
	.)			T. NORTHY		HOSPITAL	5401	040	COJET	ROAD	
	Sta	te	31. Date filed (Month, Day, Year)	3. Registrar's Signa	iture	and I					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND 17FW/5 per FIT C872 10/15/07 VS
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 2007 10:30 GEORGIA A. BOND /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b, City, Town, or Location of Death Examiner Prince George's Laurel Regional Hospital Laurel Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday) Date of Birth (Month, Day, **Funeral** Hours Days 1 M 06/21/1916 91 Missouri Director Usual Residence of Decedent 10d. Inside City Limits the Maryland 10c. City, Town or Location 10a, State 10b. County show r 28a-f show notified at 1 ☐ Yes 2 ☐ No Director Silver Spring Maryland Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with t. Department of Health and Mental Hygiene. Important: If frem 27 is marked other than "natural", or Items 230 common or other traumatic event. The Machine of the state U.S.A. 3112 Gracefield Road, #518 20904 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 🗓 No Specify: ò 3 ☐ Widowed XX Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12)
Grade 12 College (1-4or 5+) Administrator Phone Company 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Georgia Darlington George Althen ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Pers. Rep. 7157 Deer Valley Road Highland, Maryland 20777 Alan B. Helene 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial XXCremation 3 ☐ Removal from State West Arundel Crematory 10/11/2007 Odenton, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Sarvice Licensee 21. Signature of Fund Donaldson Funeral Home, P.A. 313 Talbott Avenue Laurel, Maryland 20707 **-**M00770 or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, st only one cause on each line. 23a. Part1. Enter the diseas shock, or heart failure. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Pulmonary Embolism Days /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter the carrier Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division or Vital Records, P.O. Box 68760. Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ XXVo 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably XXUnknown Dementia Cerebrovascular Accident 24a. Was an autopsy perform rmed? 2 **⊠ N**o Atherosclerotic Cardiovascular Disease 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 XX patient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 🌠 🗸 Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Injury XXNatural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 🖄 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b, Signature and fitle certifie

Registrar

10

State

3110 Gracefield Road

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Eugenio Marchado, M.D.
31. Date filed (Month, Day, Year)
0CT 1 0 2007

D 24035

Silver Spring, Maryland

October 9, 2007

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day, 06 200-Elsie M. Buccini 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Sinai Hospital Baltimore er 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Days Hours 1□M 2QF Months 219-32-0193 23, 1935 Maryland Nov. Usual Residence of Decedent 10c. Cify, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Baltimore Reisterstown 10q. Citizen of What Country? 10e. Street and Number 10f. Zip Code 322 Estate Road 21136 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or NoIf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☑ No Specify 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Housewife Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Fry Elsie George Bory 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joseph A. Buccini 322 Estate Road Reisterstown, MD Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cedar Hill Cemetery 10/9/07 Glen Burnie, Maryland Signature of Funeral Service Licensee 22. Name and Address of Facility 11824 Reisterstown Road Pa ELINE FUNERAL HOME Reisterstown, MD time ans Approximate Interval Between Onset and Death 23a. P. rt1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory shock, or heart failure. List only one cause on each line. Immediate Cause (Final disc ase or condition resulting in death) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 23d Date of delivery 2 Fetal death 3 Ectopic pregnancy Month Year Day 5 ☐ Other (specify)

Physician /Medical Examiner

the attending physician and

signed by the at d be detached for

cate has by page 2 s

filled in by the funeral

After

after death.

within 24 hours a

**Physician** 

/Medical

10a State

MD

Examiner

**Funeral** 

Director

28a-f show

5

'natural', or items 23a

permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23

Injury or other traumatic event,

Baltimore, Maryland 21215-0036

4(CIN1

Examiner must be notified at

Director

by Funeral

Completed

Be

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the Maryland

Examine Completed by Physician/Medical Be

Certification: To

Medical

To the Hospital or Attending Physician: The law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760,

IF FEMALE 23h. Was decedent pregnant in the past 12 months? ☐Yes 2☐No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical examiner?

1 ☐ Yes

27. Mayner of Death

2 ☐ Accident

3 ☐ Suicide

29a. Certifier

4 Homicide

2 No

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably

24a. Was an autopsy performed? 1∐ Yes 2 ☑ No	
Check only one)	

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

	2	<ol><li>Place of Dea</li></ol>	th (C/	neck only one)	
OA	Other:	4 ☐ Nursing H	ome	5 Residence	6 □Ot
28c.	Injury at Work?	t	28d.	Describe how inj	ury occu

elvedore are

ther (Specify) irred

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier

5 Pending investigation

6 ☐ Could not be

determined

29c. License number

1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29d. Date signed (Month, Day, Year)

30. Name and address of erson who completed cause of death (Item 23a) (Type, Print)

1 🔲 Inpatient

(Month, Day Year)

28a. Date of Injury

0 2007

State Registrar

2 ☐ ER/Outpatient 3 ☐ DOA

28b. Time of

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Injury

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Oct Zoot /Medical Facility Name (If not institution, give street and 4c. County of Death Examiner General Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) **Funeral** Months 100 M 2□F Days Hours Director 91 577-16-1701 07/17/1916 DC Usual Residence of Decedent death with the Maryland 10c. City, Town or Location r 28a-f show notified at 10a. State 10b. County 10d. Inside City Limits Director 1 ☐ Yes 2 No Ellicott City Howard 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code ral", or items 23a or Examiner must be r Funeral 5330 Dorsey Hall Drive USA 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☑Yes 2 ☐ No If Yes, Give Year or Dates: WWII 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🐼 No Specify: þ 3 Widowed 4 □ Divorced "natural", White Completed th and Mental Hygiene. 7 is marked other than "natur traumatic event, the Medical. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Unknown Elementary/Secondary (0-12) College (1-4or 5+) Unknown permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Item 27 is marked oth any Injury or other traumatic event once. 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 Unknown Unknown Unknown 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8309 Fall Chill Ct. Ellicott City, MD 21043 Marc Edward Brady, Jr./Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Oct 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory Inc. 2007 Beltsville, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Cremation and Funeral Alternatives 8717 Green Pastures Drive Baltimore, Maryland 21286 23a. Part1. Enver the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. pproximate Interval Between Onset and Death Immediate Cause (Final Atheroscleratio **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a sonsequence of): The law requires that the death certificate be executed Exami and Due to (or as a consequence of): P.O. Box 68760. physician Completed by Physician/Medical the as attending | IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a 1 ☐ Yes 2 ☐ No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 1 Tyes 2 No 3 Probably 4 Donknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has treetor, page 2 s autopsy 1 ☐ Yes 2 ☐ No or Attending Physician: funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Certification: To Be 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3□ DOA this 27. Manner of Death 28a Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1. Natural (Month, Day Year) 5 Pending investigation s after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours aft To the Funeral D completely filled in the Hospital 🕊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

State Registrar 31. Date filed (Month, Day, Year) OCT 1 0

2007

29b. Signature and title of officier

Mollis NO distrar's Signature

of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

Color Ca Columbia

29d. Date signed (Month, Day, Year)

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	1	For State Registrar	State of Ma	ryland / Depa <i>Cer</i>	rtment of Hortificate of L			ene <sub>3. No.</sub> 2 No.7	1.32310
Physicia /Medic	an	1. Decedent's Name (First, Midd		rd Bryant			2. Date of Death Month	Day Year 3, 2007	2:25 р м
Examin		4a. Facility Name (If not institution	on, give street and number) derick Villa Nursing (	Center	4b. City, Town, or	Location of Death  Baltime			imore
Funeral Director		5. Social Security Number 216-20-4576		(In yrs. last birthday) 81 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min,	8. Date of Birth (Month, Day, Mar 10, 1		rthplace (State or Foreign Country) Maryland
aryland show d at	_	Usual Residence of Decedent  10a. State 10b. Count	,	10c. City, Town or Lo		timore			10d. Inside City Limits  Y□Yes 2□No
vith the Ma t or 28a-f be notifie	Directo	Maryland  10e. Street and Number	N/A		10f. Zip Code	21229	10	g. Citizen of What C	•
partition of the light of the land of the land of the many injury or other traumant event, the Medical Examiner must be notified at any injury or other traumant event, the Medical Examiner must be notified at once.	by Funeral Director	820 North Wooding  11. Marital Status  1 Never Married 2 Ma 3 Widowed 4 Divorce	12. Was Decedent E Armed Forces? 1. ☐ Yes 2 ☐ N	° 1950 1952	Was Decedent of Hi If Yes, specify Cuba 1 □ Yes 2 🛣 No	ispanic Origin? (Span, Mexican, Puerto		Black, Wh	Black
vithin 72 ho ne. han "natur e Medical l	Completed by	15. Decede (Specify only high Elementary/Secondary (0-12)	ent's Education lest grade completed)  College (1-4or 5-	(Give	dent's Usual Occupa kind of work done of DO NOT use retired Construct	durina most of work		6b. Kind of Busines  Private	ss/Industry  Company
Idilo A	Be	17. Father's Name (First, Middl	e, Last)  dolph Bryant			18. Mother's Name		laiden Surname) Planter	
IVICAL YING AND AND AND AND AND AND AND AND AND AND	2	19a. Informant's Name/Relation	nship (Type. Print)					City or Town, State	
allimore, mit. Pages 1 an partment of Heal portant: If Item 2 y injury or other		20a. Method of Disposition  1X Burial 2 Cremation 4 Donation 5 Dother	Removal from State		osition (Name of matory or other place le Veterans Co	ce)	Date 2	20c. Location - City Crowns	or Town, State ville, Md.
paint. permit. Departm Importa any inju	<	21. Signature of Fundat Servin	Licensee	2	2. Name and Addrese Estep Br 1300 Fur	ss of Facility others Funera taw Place Ba	al Service, P. timore, Md 2	A 21217	
Physician // Medical Examiner physician and physician and stee physician and steep phy	al Examiner	22s. Fartt. Enter he disdese, shock, or art failure. L immediate payse (Final disease or indition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that imitiated events resulting in death) Last	b	a consequence of): a consequence of):	Bowel	ObsT	rutio	1	Approximate Interval Between Onset and Death
ath certif	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	d	2 Fetal death 3	□Ectopic pregnanc	у		23d. Date of Month	delivery Day Year
us, r.C. I	by	Part II. Other significant cond		ut not resulting in the t	underlying cause giv	ven in Part I.	23e. Did tob		e to the cause of death?  Probably 4 □Unknown
VILAI NECOLO sician: The law require certificate has been si irector, page 2 should b	Completed							med? prior death	e autopsy findings available to completion of cause of n? (es 2 \sum No
on or sing Phy L. After this funeral d	Certification: To Be	3 Suicide 6 Cou	Hospital: 1 Inpatie  28a. Date of Inju (Month, Da)  stigation Id not be  28e. Place of Inju	ry 28b. Time	of 28c. Inju	her: 4 Nursing H rry at rrk? Yes 2 No	28d. Describe ho	ence 6 Other (Sow injury occurred	Specify) r Rural Route Number,
To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the		(Check only 2 Medi	fying Physician: To the best cal Examiner: On the basis o	of examination and/or	ath occurred at the t investigation, in my	time, date and place opinion, death occ	e, and due to the curred at the time, c	cause(s) and manne date and place, and	er as stated. due to the cause(s)
To the I- within 24 To the F	Medical	29b. Signature and title of cer	and manner st	tendin		se number	2	29d. Date signed (M	onth, Day, Year)
· }		30 Name and address of per	son who completed cause of c	death (Item 23a) (Ty	Print) NR	olling (	ed ste	25	71728
S	tate	31. Date filed (Month, Day, Yo		rar's Signature	all				

DHMH 17 Rev 1/2001

07-07614 Vincent Fields

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2007 32311

		- For State			Certifica	ate of	Death					eg. No.				_
Physicia		Registrar 1. Decedent's Name (First, Middl	cedent's Name (First Middle Last)											3	I. Time of Death	
ledical Examir		Vincent Fie	elds B	rown						$\perp$	Month September	er 28, 2	2007 2007		0820 hrs	_
		4a. Facility Name (if not institution				4	b. City, Tow	n, or Lo	cation of	Death		4c.	County of	Death		
		3800 West Belvedere				]	Baltimo	re				1	N/A			
Europol	+	5. Social Security Number	6. Sex	7. Age (	In yrs. last birt	thday)	If Under 1	Year	If Under	24Hrs.	8. Date of B	rth(MM/l	OD/YYYY)	9. Birth	place (State or	
Funeral Director								Days	Hours	Min.	0 4 1 4 0	/10		Foreign Cour	ntry) Md.	- 1
Bircotor	L	214-54-4247	1X M 2	F	58	Yrs.					04/10	119	49		· ma ·	$\dashv$
		Usual Residence of Decedent  10a. State 10b. County			0c. City, Town	or Locatio	on								10d. Inside City Limit	ts
w any		10a. State 10b. County		1"	•										1 X Yes 2 N	10
Aaryland 28a-f show 1 at once.	5	Md.	N/A		Bal	time						10 0111	zen of Wha			$\dashv$
ith the Maryland 23a or 28a-f sho notified at once	ect	10e. Street and Number					10f. Zip C	ode				10g. Citi	zen or vvna	at Count	ıyı	1
the la or	ā	3800 West Be	elverde	re Av	venue			.215				USA				
with ns 23	Funeral Director	11. Mantal Status	12. Was	Decedent E		13. Wa	s Decedent	of Hisp	anic Ongi	n? (Spe	ecify Yes or N	lo-	14. Race - White		an Indian, Black,	
leath riten	핅	1 X Never Married 2 N	Married 1 Arme	d Forces?	No	IT Y	es, specify	Juban,	MEXICALI,	rueitoi	doarr, etc. j	l	***************************************			
fler of		3 Widowed 4 Div	vorced If Yes, Give	Yeer			Yes 2						Specify:	Bla	.ck	_
hours after "natural";	d b	15. Decedent's Education (Spe	ecify only highest	grade comp	leted) 16a.	Deceden	n's Usual O	cupatio	n (Give k	ind of w	ork done	16b. I	Kind of Bus	siness/In	dustry	
2 ho	ompleted	Elementary/Secondary (0-12)	) Colleg	e (1-4 or 5-	+)	during m	ost of worki	ng lite.	DONOT	ise reur	su)	1				
thin 36	힐	12				Dis	able	ı				Pr	ivat	e Co	onstruct	<u>,iφ</u> ,
d wii	히	17. Father's Name (First, Middle	e, Last)					1	8.Mother's	s Name	(First, Middle	, Maiden	Surname)			- 1
215-0036 be filed within 7 ntal Hygiene. rked other than ent, the Medica	Be (	John Field	10						Laur	·a	Field	ds				
213 buld b Men mari		19a. Informant's Name/Relation		)				(Street	and Num	ber or R	ural Route N					
MD 21215-0036 at 2 should be filed within 72 hours after death with the Maryland alth and Mental Hygiene. m 27 is marked other than "natural", or items 23a or 28a-f shraumatic event, the Medical Examiner must be notified at once		Jacquline Ja	acobs		7-	120	Park	Не	ight	s A	venue	e,Ba	ıltin	nore	o, Md. 212. Town, State	15
and and tealth	ŀ	20a. Method of Disposition						of cem	netery,		Date	20c.	Location -	City or	Town, State	
imore, MD 21215-0036 Pages I and 2 should be filed within 72 nent of Health and Mental Hygiene. ant: If item 27 is marked other than 'or other traumatic event, the Medical		1 X Burial 2 Crematic	on 3 Remov	al from Stat	te crema	atory or of	ther place)		<b></b>	10/	c /200	7 D	07+1	man	o Md	- 1
Fant trant	- [	4 Donation 5 Other S			King	Mer	noria	, <u>1</u>	of Facility	10/	6/200	1 B	alti	пот	e,Md.	$\neg$
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 77 Department of Health and Mental Hygiene. Important: If item 27 is marked other than injury or other traumatic event, the <u>Medical</u>	ı	21. Signature of Funeral Service	Signature of Funeral Service Licensee 22. Name and Address of Facility Estep Brothers Funeral Home, 1300 Eutaw Place, Baltimore,										, P	$^{ m A}$ 21217	<sub>z</sub>	
		Occ	Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hea											art	Approximate Inter	_
Physician		23a. Part I. Enter the disease, of failure. List only one caus	e on each line.							ai uiac o	respiratory	arroon, or	10011, 01111		Between Onset at Death	
/Medical Examiner	1	Immediate Cause (Final diseas	<sub>e a.</sub> Hyperte	ensive At	herosclero	tic Card	liovascul	ar Dis	ease					_	- Julian	-1
	- 1	or condition resulting in death)	Due to (or	as a conse	quence of):											
	_	Sequentially list conditions,	b				_			_						$\neg$
	<u> </u>	if any, leading to immediate cause. Enter Underlying Cause		as a conse	equence of):											
11 -	Examine	(Disease or injury that initiated events resulting in death) Last		as a conse	equence of):											Î
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ial a	n/Medical	UNPENDED	AMENE	DED												
8760, tificate be ex ng physician as the burial	Nec	IF FEMALE:	23c. If	yes, outcom	ne of pregnan	су						2	3d. Date o			
876 rtificate ing phy as the	2	23b. Was decedent pregnant in past 12 months?	the 1 l	ive birth		2 🗌 F	etal death	3	Ectopi	c pregn	ency		Month	1	Day Year	l
Box 68 e death certi the attendin	:0		I	Pregnant at Heath	time of	5 (	Other (Spec	ify)				1				
e des	Physicia			Jnknown						1	220 D	id tobacc	CO USE CON	ribute to	the cause of death?	?
P.O. Box 687 s that the death certifice gned by the attending p	Ϋ́	Part II. Other significant cond	ditions contribu	ting to deatl	h but not resul	Iting in the	e underlying	cause	given in P	art I.	11	Yes 2			babiy 4 Unknow	- 1
sign lbe d	Completed by	Diabetes mellitus											100000000000000000000000000000000000000		utopsy findings avail	
required peen	lete											utopsy		prior to	completion of cause	
e law e has	E D											erformed es 2 🗸		death?	es 2 No	o .
Division of Vital Records, spital or Attending Physician: The law requirement after death.  reral Director: After this certificate has been stiffled in by the funeral director, page 2 should it		25. Was case referred to media	ng!					26 Plac	e of Death	(Check	only one)					
ician s cert recto	Be	examiner?	Hospital:	Innetic	ent 2 EF	R/Outpatie		OA	Other:		ng Home 5	Res	idence 6	<b>✓</b> Othe	er: Scene	
f Vi Physi er this	၉	1 Yes 2 No 27. Manner of Death	289	Date of Inju		Bb. Time o			iry at Wor				injury occu			$\overline{}$
n of ding Pl After funeral	ë.	1 M Notinal	ending	(Month, Day,		35. 11110	,,		Yes 2							
Sio Vitten deatl ctor:	cati		vostigation	-	njury - At home		land footon	office	building 4	etc	28f Locati	on (Stree	et and Num	ber or R	lural Route Number,	City
I or /	ij		ould not be		njury - At nom	e, rarm, si	reet, ractory	, onice	Dundang, v	oto.		vn, State				
Division Hospital or Attenc 24 hours after death Funeral Director: tely filled in by the	Certification:	4 Homicide	(0)	ecify)					-			(2)	and mann	or as ets	ated	
= 2 = 5		29a. Certifier 1 Certifying (Check only one) Medical E	Physician: To to xaminer:On the	he best of n	ny knowledge,	death oc	curred at the	e time, o	date and p on death o	olace, ar occurred	at the time,	cause(s) date and	place, and	due to 1	the cause(s)	
To the II within 24 To the F	Medical		and ma	nner stated		701 11146311									lonth, Day, Year)	
	Σ	29b. Signature and title of cert	titier	_	7		29		se numbe	21			eptemb			
		(al. 11)	121	1	7.			O.C	.M.E.			s	eptemb	⊕ 3U,	2007	
1		30. Name and address of pers	son who complete	d cause of	death (Item 2	3a)										
\		Zabiullah Ali, M.D.	Assistant N	/ledical E	xaminer	111 P	enn Stre	et, Ba	ltimore,	MD 2	1201					
S	tate	31. Date filed (Month, Day, Yea	ar)	32. Registr	ar's Signature	1.24	٠									
Regis	trar	007.1	0 2007	199.0	in the	1	astis									

COME

07-07057 Rubin C. Carter

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

ubin C. Carter	State of Maryland / Department of Health and Mental Hygiene  1- For State  Certificate of Death  Reg. No.  2007 323								3231				
Physician		Registrar  1. Decedent's Name (First, Middle,Last)						Date of Death     Month Day Year				e of Death	
		Rubin Clifton Carter				Septemb	September 10, 2007			15 hrs			
	•	4a. Facility Name (if not institution, give street and number)		4	4b. City, Town, or Location of Death			h	4c. County of De Prince Geo				
		Prince George's Hospital Center	On one to	and bright along	Cheverl		f Under 24Hr	0 Data of F		D/YYYY) 9. B		(State or	
Funeral Director				ast birthday)	If Under 1 Months		Hours Mir	1.		Fore	ign ountry)	DC	
Director	_ L	579-66-4017   1XM 2 F 5	9	Yrs.			42.3	June	2 1	948	ouritry)		
any	-	Usual Residence of Decedent  10a. State 10b. County	10c. City,	Town or Location	on						10d. lr	nside City Limits	
<u>* .</u>	_	DC	Was	hingto	n						1 🔀	Yes 2 No	
re Maryland or 28a-f show	8	10e. Street and Number			10f. Zip Co	ode			10g. Citize	en of What Co	untry?		
the Milited	Director	2901 Langston Pl SE			20	020		77.71	U.S	.A.			
72 hours after death with the Maryland n "natural", or items 23a or 28a-f sho al Examiner must be notified at once	ᇎᅡ	11. Marital Status 12. Was Decedent I	er in U.					Specify Yes or N	lo- 1	14. Race - Ame White, etc.	erican Inc	lian, Black,	
death or iten	Funeral	1 Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc.											
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hours	9	15. Decedent's Education (Specify only highest grade com Elementary/Secondary (0-12) College (1-4 or 5					NOT use re		160. KI	ind of busines	s/industry		
36 in 72 in dical		10th	• )	Labor	er				Pr	ivate		. =	
5-0036 led within 72 hours after tygiene. other than "natural", the Medical Examiner	Completed	17. Father's Name (First, Middle, Last)				18.	Mother's Nam	e (First, Middle	, Maiden S	Surname)			
21215-0036 Mental Hygiene. Mental Hygiene. c event, the Medica		Clifton Carter				_		ice Ro					
D 21 should and Mer 7 is man		19a. Informant's Name/Relationship (Type, Print )		19b. Mailing	Address	Street an	nd Number or	Rural Route N 222 Wa	umber, Cit	y or Town, Sta	te, Zip C	ode) 20020	
도 등 보고 를	- 1	Hunnora Carter-Mayrant	Loop	Place of Disposi				Date		ocation - City			
5 2 E E	- 1	20a. Method of Disposition  1 X Burial 2 Cremation 3 Removal from Sta	1	crematory or oth	er place)	or cemen	Se	ptembe	r Si	itlan		I	
imC Page ment tant:		4 Donation 5 Other Specify:	106					, 2007	400				
Baltimore, permit. Pages lar Department of Hea Important: If iten injury or other tr		21 Signature of Funeral Service Licensee	()					IcLaug SE Wa					
Physician	+	23a. Part I. Enter the disease, or complications that caused	the death								Арр	roximate Interval	
/Wedical	-	failure. List only one cause on each line.					* 21	* > 1			Bet	ween Onset and Death	
xaminer	-	Immediate Cause (Final disease or condition resulting in death)  a. Narcotic i  Due to (or as a conse									1		
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0, e be ex sician sician	edical	UNPENDED #45a,27,28	a-f, p	erME,g872	2, 10/1	1/07	TT		100	Data of dalling			
Box 6876/ e death certificate the attending phy ed for use as the b	إ	IF FEMALE: 23b. Was decedent pregnant in the	ne of preg	inancy	tal death		Ectopic preg	nancy		d. Date of deliving Month	Day Day	Year	
× 6	sician/M	past 12 months?	time of de		ner (Specif	/)							
BO te deat the at	Phys	1 Yes 2 No 9 Unknown g Unknown			4 12		a la Bad l	220 Die	tobaccou	uso contribute	to the ca	use of death?	
that the	ğ	Part II. Other significant conditions contributing to death	i but not r	esulting in the t	inderlying c	ause give	en in Parti.			bbacco use contribute to the cause of death?  2 No 3 Probably 4 ✔ Unknown			
IS, F												findings available	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 11. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 12. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 12. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 12. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 12. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 12. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 12. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 12. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 12. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 12. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 12. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 12. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 12. Other significant conditions conditions that can be supported by the part of t								_ au	topsy rformed?	prior t death		tion of cause of	
tal Rec					1 ✔ Ye	s 2 N	0 1 🗸	Yes	2 No				
ician:	Be	examiner?	25. Was case referred to medical examiner? [Hospital:   Innation: 2   FR/Outnation: 3   DOA   Other;										
Physical distribution	의	1 Ves 2 No 1 mpatter  27. Manner of Death 28a. Date of Inju	1 V Yes 2 No Inspired 1 Inpatient 2 V ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other:										
ion of V tending Phr eath. for: After the funeral	Certification:	Natural 5 Pending FNd 9/10/2007 FNd 7:27 pm 1 Yes 2 X No unk											
Visior or Attencurer death Director: in by the	<u>[</u> ]	2 Accident Investigation 28e. Place of In	jury - At h	ome, farm, stree	et, factory, o					nd Number or	Rural Ro	ute Number, City	
Div	=	Suicide 6 X Could not be determined (Specify)	ind ir E. Wa	in dirt area 4527 Gault Pl. P.G. County Hospital, Washington, D.C.								nington, DC	
293. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and ma (Check only one) 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, a and manner stated.										d manner as s	tated.		
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		Theodor U. Kers	( )	quen		O.C.M.	□. ·		Sep		, 2007		
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Sta Registr		31. Date filed (Month, Day, Year) 2007 32 Registra	July 1911	and the same									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Amend #17,perFH,g872,10/16/07 TT Certificate of Death 32313 Reg. No 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Stace avv 2216 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Union Mem. Hospital Baltimore NA If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Days Months Hours Min. 216-02-2703 Director 32 7-9-1975 Md. Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show must be notified at Md. NA Director Baltimore Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 1110 Somerset St. 21202 or items 23a USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status r than "natural", or iten the Medical Examiner Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify ģ Black 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th grade Case Manager, Social Services State of Maryland 7 Is marked other traumatic event, the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) **Pranch** Be Grafton **Branck** Jacqueline Lewis ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If Item 27 Is any Injury or other trauonce. Rodney O. Carr Husband 1110 Somerset Street, Baltimore, Md. 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Garrisson Forest Vet.10-12-07 Owings Mills, Md. 21. Signature of Funeral Service Licensee March F.H. East Y la 1101 E. North Ave., Baltimore, Md. 21202 01 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical as a consequence of): sod 5 hry Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed inding physician and use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) signed by the a d be detached for 1 ☐ Yes 2 ☐ No 9 ☑ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2₽No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □ No 24a. Was an autopsy 2 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2F-110 ၀ 1 Inpatient 2 ER/Outpatient 3 DOA this within 24 hours after death.

To the Funeral Director; After thi completely filled in by the funeral is 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 28d. Describe how injury occurred Injury at Work? 5 ☐ Pending investigation 1 Matural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 201 E. Unaryidy

State Registrar Garffulle

2007

10 M

31. Date filed (Month, Day, Year)

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Lyon

3 Règistrar's Signature

DHMH 17 Rev 1/2001

Hospiba

Manoral

State

Registra

31. Date filed (Month, Day)

1 0

32 Registrar's Signature

Months

4b. City, Town, or Location of Death

If Under 1 Year | If Under 24 Hrs.

Hours

BALTIMONE

Days

1242

Birthplace (State or Foreign Country)

10d. Inside City Limits

1 ☐ Yes 🎗 ☐ No

Maryland

White

Hospital

Approximate Interval Between Onset and Death

10 1/2 110025

UNKNOWN

Day

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

Year

23d. Date of delivery

Month

10108/07

4c. County of Death

8. Date of Birth (Month, Day, Year) May 7, 1936

BALTIMONE CITY

USA

Specify:

14. Race - American Indian,

Physician
/Medical
Examiner

1 - For State Registrar

10a. State

MD

Social Security Number

219-32-9470

Usual Residence of Decedent

4a. Facility Name (If not institution, give street and number)

JOHNS HOPKINS BAYVIEW MESILL CENTER

6. Sex

Baltimore

1**X** M 2 ☐ F

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2007

32 Registrar's Signature

RONALD PAVLOINE MO

OCT 1 0

31. Date filed (Month, Day, Year)

**Funeral** 

Director Pages 1 and 2 should be filed within 72 hours after death with the Maryland iral", or items 23a or 28a-f show Examiner must be notified at "natural" Department of Health and Mental Hygene. Important: If item 27 is marked other than "natui any injury or other traumatic event, the Medical once.

**Physician** 

Baltimore, Maryland 21215-0036

/Medical Examiner

the Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans ed by the a detached f this I Director: And in by the f n 24 hours after der ne Funeral Directo pletely filled in by th within 24 hor To the Fune completely fi

Division or Vital Records, P.O. Box 68760,

Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 157 Riverside Road 21221 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married by 1 ☐ Yes 2 No Specify: 3 ☐Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Franklin Square Security Guard 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be James Eagle Eva H. Wirth ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jacqueline Eagle /wife 157 Riverside Road Baltimore MD 21221 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Bayview Crematory 10/9/07 Baltimore MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 300 Mace Ave Balto. MD Connelly Funeral Home of Essex 23a. Part1. Enter the disease, or complications that caused the Jeth. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) RUPTURED Averic ANEURISM Due to (or as a consequence of): HEROMINAL ADATIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Due to (or as a consequence of) Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) 9∏Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Chrenosis 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an Coperagny ANTERS PIRESA autopsy performed? 1□ Yes 2 🛣 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 1 🔀 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 🔀 Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

7. Age (In vrs. last birthday)

10c. City, Town or Location

Essex

DHMH 17 Rev 1/2001

State

Registrar

D 44849

4940 BASTURN ANOWE BALTIMONE MD 21224

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
AVEND TIEM#20b, per FH, G872, 10/10/07, WS
State of Maryland / Department of Health and Mental Hygiene 0 7 For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Edwards **Physician** Hattle 11:05 PM octuber 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner University of Margiand Medical Center WIA Bathmore Uti If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Months Days Min. Hours 1 M 2 F Director Apr 19, 1963 Maryland Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County ns 23a or 28a-f show must be notified at 1 Y Yes 2 □ No Director N/A Baltimore Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number by Funeral 1359 Gilmor Street 21217 U.S.A. 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or items 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. unt: If item 27 is marked other than "natural", or iten 1 X Never Married 2 ☐ Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: Specify 3 Widowed 4 Divorced Black Be Completed th and Mental Hygiene.
7 is marked other than "natur traumatic event, the Medical! 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) **YMCA** Receptionist 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Margaret Edwards Basil James Edwards 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 other to Margaret Edwards Mother 1359 Gilmor Street Baltimore, Maryland 21217 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ethod of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Dopation 5 □ Other (Specify) Department of Important; If it any Injury or o once. Metro Crematory 10/13/07 Baltimore, Md Western Cometery 21. Signature of Funeral Service Licensee Estep Brothers Funeral Service, P. A.

23a. Part1. Enter the disease, or competications that caused the death. Do not enter the model of the supplier of the s Approximate Interval Between Onset and Death Immediate Cause (Final Sepsis **Physician** day disease or condition resulting in death) /Medical Due to (or as a consequence of): 5 days Examiner Pheumonia Sequentially list conditions, Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transi Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) signed by the at d be detached fo 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by Immunodeficiency Virus 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autopsy performed' death? certificate 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be examiner? 1 ☐ Yes 2 No Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) ပ this 27. Manner of Death 1 Natural 28a. Date of Injury 28h Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: After (Month, Day 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: completely filled in by the 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

Registrar

State

SIATEN

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

WID

Bernadelle C. Slaton, MO

OCT 1 0 2007

31. Date filed (Month, Day, Year)

P21146

22 South greene Freet Bultimore Maryland 21201

October-

LOO7

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Physici<u>an</u> Ferrel1 Geraldine Grev /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Glen Baltimore Washington Medical Anne 8. Date of Birth (Month, Day, Year) 5. Social Security Number If Under 1 Year | If Under 24 Hrs **Funeral** 1 M 2 F Days Months Director 220-24-6280 July 20,1930 West Virginia Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show 1 ☐ Yes 2 ☐ Xo notified Funeral Director Anne Arundel Glen Burnie Maryland| 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code ral", or items 23a or Examiner must be U.S.A. 7853 Crilley Road 21060 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ XNo Specify. Completed by 3 ☐ Widowed 4 Divorced White "natural" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 72 hc Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natu my injury or other traumatic event, the Medical 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 N/AElectronics Technician Westinghouse 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Voise11e Mona ျှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rader (Brother) 1312 Thomas Road Pasadena, Maryland 21122 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Glen Haven Mem. Pk. 10/10/07 Glen Burnie, Maryland 21. Signature of Funeral Service Licensee McCully-Polyniak Funeral Home, P.A. 3204 Mountain Road Pasadena Maryland 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** resulting in death) /Medical Ulmonary Disease Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Exami Due to (or as a consequence of) attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 ☐Ectopic pregnancy Month Dav 4☐Pregnant at time of death 5 Other (specify) 9☐Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 🗆 No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perform 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 TYes 2 ER/Outpatient 3 DOA Certification: To 27. Man r of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760,

ours after death. within 24 hours at To the Funeral D completely filled i

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated.

29b. Signature and title of certifier

29c. License number D 41365

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Orive, Glen Burnie, MD. 21061

32. Registrar's Signature

le DE MD.

State Registrar

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death Month . Decedent's Name (First, Middle, Last) Day **Physician** toster OKN 100 200 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE AGNES HOS PITAL If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. | (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday, 5. Social Security Number 6. Sex **Funeral** Months 1 M 2 □ F 78 226-34-764 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10b. County an "natural", or items 23a or 28a-f show Medical Examiner must be notified at 1 res 2 No Baltimore Director MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Monroe 21211 1606 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 11. Marital Status 1 ☐ Never Married 2 ☑ Married Black 1 ☐ Yes 2 ☑ No Maryland 21215-0036 Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 7 is marked other than traumatic event, the Me College (1-4or 5+) Elementary/Secondary (0-12) abover 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any injury or other traumatic event Be A 20 Co allie toster 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Dalto. MD Monroe roste 1606 1 ola Baltimore, 20b. Place of Disposition (Name of cemetery crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore 10 601 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee Funeval Rd rough Ra Lallstown. MD 21133 8728 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician ASPIRATION PNEU MONIA /Medical Due to (or as a consequence of): **Examiner** Un kno wa ecubitus Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine ng physician and as the burial-transit Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 Physician/Medical the attending population that the attending population at IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) detached 9 Unknown signed by 23e. Did tohacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an has autonsy performe this certificate 2 No director, 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2No 2 ER/Outpatient 3 DOA 1 🗌 Yes 2 To the Hospital or Attending Phywithin 24 hours after death.

To the Funeral Director; After thi completely filled in by the funeral of 28c. Injury at Work? 28b. Time of 27. Manner of Death 28a. Date of Injury 28d. Describe how injury occurred al or Attending P s after death. Certification: (Month, Day Year) Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier B14 OCT 02, 200 COURTO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CTIENNE 900 CATON Ave DALTIMORE NGOUNCANA 32 Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar 0 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 14, 17, 18 per inf 9878 4-24-08 vt. State of Maryland 7 Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Physician 2007 1315 Marguarite Bordenave Gusmann October /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince George's Mitchellville Mitchellville

| If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year)
| Months | Days | Hours | Min. | Aug. 24, Villa Rosa Nursing Home 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Year) 1 □ M 2√2 F Yrs. 100 1907 Louisiana Director 438-76-5479 Usual Residence of Decedent 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits show r 28a-f show notified at 1 X Yes 2 □ No Director Louisiana Orleans New Orleans 10g. Citizen of What Country? 10e. Street and Number 10f. Zin Code th and Mental Hygiene.
7 is marked other than "natural", or items 23a or traumatic event, the Medical Examiner must be I 821 Burmaster Street 70053 U.S.A. Funeral death Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Black, White etc. **Mulatto** Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Be Completed by 3 Widowed 4 □ Divorced **Black** 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 12 17. Father's Name (First, Middle, Last)

C. Bordenave 18. Mother's Name (First, Middle, Maiden Surname)
Carnouche ဥ Gaston G. Chachere Edna Caronouch 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) of Health a Department of Health Important: If item 27 any injury or other tr Carolyn G. Chachere (Daughter) 938 Franklin Ave., Gretna, LA 70053 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Doration ☐ Other (Specify) 10/20/07 St. Mary's Cemetery Algiers, LA 22. Name and Address of Facility Rhodes Funeral Home 21. Signature of Funcial Service Licensus 1020 Virgil St., Gretna, LA 70053 um 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 5+99 **Physician** End /Medical Due to (or as a consequence of): Examiner Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical as aftending p for use as IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☑ No 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown certificate has been si rector, page 2 should I Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? res 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) director Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 X Natural 5 Pending investigation after death.

I Director: Af
d in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in 24 hours.
the Funeral Directory filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical within 24 ho

To the Fun

completely and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar Rakesh Arora, M.D.
31. Date filed (Month, Day, Year)
OCT 1 0 2007

14300 Gallant Fox La., Bowie, MD 20715

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1 - For State Registrar	•	,	ertificate of l			2007	331232			
Physi	cian	1. Decedent's Name (First, Middle, Last)					Month	Day Year	9:00 PM			
/Med		4a. Facility Name (If not institution, give s			4b. City, Town, or	Location of Death	OCTOBER	4c. County of Dea				
Exam	iiiei	BACTIHORE - WASHING	Аріазн цот	CENTE	Wald &	BURNIC	2	A 3444				
Funera	1	5. Social Security Number 6. Sex	7. Age (In	yrs. last birthday	/) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, )	(ear) 9. Bir	thplace (State or Foreign ountry) ryland			
Directo	r	216-62-8362		52 Yrs.			Sept.18	8,1955 Ma	ryland			
/land		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location										
Mary a-f sh ified	ctor	Maryland Anne Aru	ndel S	Severna 1	Park	ark			1 □Yes 2□Alo			
<b>BAITIMOTE,</b> IMARYIAND Z1Z13-UU3D permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.	Direc	Maryland Anne Arundel Severna Park  10e. Street and Number 10f. Zip Code 10f.							ountry?			
	ra	538 St. Martins La	ne		2114			U.S.A.				
er de items	Funeral	11. Marital Status  1 □ Never Married 2 ☐ Married	12. Was Decedent Ever Armed Forces? 1  Yes 2 No	in U.S.   13	Was Decedent of H If Yes, specify Cuba	ispanic Origin? (S) an, Mexican, Puert	o Rican, etc.)	Black, Whi				
JSD ars aff	by F	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 □ Yes 2 □XNo	Specify:		Specify:	hite			
21215-0036 ad within 72 hours af giene. er than "natural", or , the Medi al Exami	Be Completed	15. Decedent's Edu (Specify only highest grade	cation	16a. Dec	edent's Usual Occup	ation during most of wor	kina 10	6b. Kind of Business				
ZT:	nple	Elementary/Secondary (0-12)	College (1-4or 5+)		ve kind of work done of DO NOT use retired				1 1			
led w Hygier her th	ပ်	17. Father's Name (First, Middle, Last)	N/A	Co	rrectional		ne (First, Middle, Mi	tate of M	aryland			
anc d be fi antal H ed of	Be	Andrew	Ε.	Gille.	spie	Mary	D.	,	acobs			
Maryland  od 2 should be file lith and Mental Hy 27 is marked other rtraumatic event	2	19a. Informant's Name/Relationship (Ty			iling Address (Street	and Number or Ru	ıral Route Number,	City or Town, State,	Zip Code)			
Michael alth a alth a 127 is		Nancy L. Gillespie	(Wife)	538	St. Martin	ns Lane S	Severna Pa	rk Maryla	nd 21146			
or He		20a. Method of Disposition 1 ☐ XBurial 2 ☐ Cremation 3 ☐ R	lemoval from State	20b. Place of Disp cemetery, cr	position (Name of rematory or other plac	ce)	Date 2	Oc. Location - City of	Town, State			
Pag ment ment ant: I		4 Donation 5 Dother (Specify)		Crownsy	ille V.A.	Cem. 10/	12/07	Crownsvill	e, Maryland			
Baltimore, permit. Pages 1 ar Department of Hea Important: if item; any injury or other	5	21. Signature of Funeral Service Licens	llens.	,	22. Name and Addre McCully-Po 3204 Mount	ss of Facility Olyniak F Lain Road	Tuneral Ho I Pasadena	ome, P.A. a. Marylan	d 21122			
		McCully-Polyniak Funeral Home, P.A. 3204 Mountain Road Pasadena, Maryland 21122  23a. Papt. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Be Onest and Pasadena										
Physicia	n	Immediate Cause (Final disease or condition  a. CONCESTIVE HEART FAILURE  System in death)  a. CONCESTIVE HEART FAILURE										
/Medica Examine		resulting in death)	Due to (or as a co	onsequence of):					10 YEARS			
LAGIIIIIC	<b>.</b>	Sequentially list conditions, b. COROULLY ARTERY DISEASE  Due to (or as a consequence of):										
nted Insit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury										
O, exect an and rial-tra	Exa	that initiated events resulting in death) Last	Due to (or as a co	onsequence of):								
68760, — ficate be executed physician and is the burial-transit	edical	<u>8</u>										
, P.O. BOX 68760, — that the death certificate be executed ed by the attending physician and detached for use as the burial-transit	Med	IF FEMALE: 23c. If yes, outcome pf pregnancy										
death certi	Physician/M	23b. Was decedent pregnant in the past 12 menths?	у		23d. Date of de Month	Plivery Day Year						
hat the de de by the setached is	ysic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4□Pregnant at tim 9□Unknown									
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ecord law requii as been s 2 should	Completed	24a. Was an autopsy							24b. Were autopsy findings available prior to completion of cause of			
Or VItal HeC Physician: The lav r this certificate has ral director, page 2:	l e					perform 1 Yes 2	ed? death? Land death? Land death?	-				
/ita clan: entific ector,	Be (	25. Was case referred to medical examiner?	In mittals		100		ath (Check only one	one)				
VISION OF VITAI RECORDS, Attending Physician: The law requires t releath. ector: After this certificate has been signe by the funeral director, page 2 should be or	2	Till fes 2 100	lospital: 1 Inpatient 28a. Date of Injury	2 ER/Outpati		4 LI Nursing F	fome 5 ☐ Resider	nce 6 Other (Sp	ecify)			
ding I	ion:	27. Manner of Death  1 Natural 5 Pending investigation	(Month, Day Ye		/ Wor	rk? Yes 2∐No	200. Describe not	w injury occurred				
Division I or Attending after death. Director: After	fical	3 Suicide 6 Could not be	28e. Place of injury	At home, farm,		tory, office 28f. Location (St.		reet and Number or Rural Route Number,				
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Division or  To the Hospital or Attending Ph within 24 hours after death.  To the Funeral Director: After th completely filled in by the funeral	Medical (	29a. Certifier 1 Certifying Phy (Check only one)	(Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)									
o the ithin 2 o the omple	Mec	29b. Signature and title of certifier	and manner stated		29c. Licens	se number	29	29d. Date signed (Month, Day, Year)				
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10.4		30. Name and address of person who co		n (Item 23a) (Typ		111		1 - 0 - 1 -	<u> </u>			
	4	0 1.										
6.4		31. Date filed (Month, Day, Year) OCT 1 0 200	CIFFICKEC	O 301 U Signature	ad Jati 920.	ive, Gle	BIUAUBY	HD 201	61			

DHMH 17 Rev 1/2001

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** October 200 Gasiorowski Francis /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Burnu Anne Glen Baltimore Washington Modical Center If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Months Days | Hours | Min. | October 3 1921 5. Social Security Number **Funeral** Months 86 Baitimore, Maryland 220 07 0333 1 M 2 □ F Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f shov iral", or Items 23a or 28a-f shov Examiner must be notified at Maryland Harford Joppa 1 ☐ Yes 2 No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21085 1702 Little Britian Court USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ★ Yes 2 □ No If Yes, Give Year or Dates: ₩₩ II Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 X Married 1 ☐ Yes 2XX No Baltimore, Maryland 21215-0036 Specify. þ White 3 Widowed 4 Divorced Completed permit. Pages 1 and 2 should be filed within 72 hc Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natur any injury or other traumatic event, the Medical eney. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) N/A Painter Painting Local 101 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Anastazya Sielangowska Frances X Gasiorowski ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1702 Little Britian Court Joppa, Maryland 21085 Joyce Crook (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Parkwood Cemetery October; 11 2007 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Lassahn Funeral Home Inc 21. Signy ture of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Accident Immediate Cause (Final evebrovascul Physician disease or condition resulting in death) /Medical **Examiner** herosclerosis if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 by Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Day in the past 12 months? Month Year 5 Other (specify) 1 ☐ Yes 2 ☐ No the 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? 2 No 1∏ Yes 2 NO 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes Hospital: 2 No 1 inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death in by the funeral 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred : After 1 Natural (Month, Day Year) Injury 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 Homicide within 24 hours aft To the Funeral DI completely filled in 1 🖰 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier October 6, 2007

State Registrar t

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

795 lorowski

62. Registrar's Signature

on who completed cause of death (tem 23a) (Type, Print) ospital Drive, Glen Burnie, MD, 21061

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Funeral		5. Social Security Number 6. 9		irthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Day		9. Birt	hplace (State or Foreign		
Director		212-34-1230	I □ M 2 <b>X</b> F	69	Yrs.	Months Days	Hours Min.	6-7-1		Couintry) Md		
land bw		Usual Residence of Decedent  10a. State 10b. County	10c. City, To	wn or Lo	ocation		10d. Inside City Limits					
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ith the or 28; se not	Dire	10e. Street and Number				10f. Zip Code			10g. Citizen of	What Co	untry?	
eath w is 23a must l	Funeral Director	2803 Ulman Avenue  11. Marital Status  1 □ Never Married 2 □ Married  1 □ Never Married 2 □ Married  1 □ Yes 2 □ No   f Yes, Give Yes			21215  13. Was Decedent of Hispanic Origin? (Spelf Yes, specify Cuban, Mexican, Puerto					SA	rican Indian,	
or item	Fun							Black, White, etc.				
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443g		19a. Informant's Name/Relationship John Presley Gary	**	_		-	view Rd.,				21215	
Datifinore, Mispermit. Pages 1 and 2 Department of Health a Important: If Item 27 is any injury or other trau		20a. Method of Disposition	35 1/ 0: -	20b. Place cemet	of Dispo	osition (Name of matory or other place	1	Date	20c. Location			
Dartillior  Permit, Pages Department of I  mportant: If it any injury or o		1 Burial 2 □Cremation 3 □ 4 □Donation 5 □ Other (Speci		Garr:		Forest V		11-07	Owings	s Mi	lls, Md	
Darti permit. Departi Importa any inju		21. Signature of Funeral Service Lice	nsee	_ )		2. Name and Addre	ess of Facility Ma North Ave	arch F.H . Balti		/d.	21202	
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ath certif	n/Me	IF FEMALE: 23b. Was decedent pregnant	Was decedent pregnant in the past 12 months?  1 ☐ Yes ✓ No  23c. If yes, outcome pf pregnancy  1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  4 ☐ Pregnant at time of death 5 ☐ Other (specify)						23d. Da	23d. Date of delivery Month Day Year		
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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	rtific									reet and Number or Rural Route Number, ı, State)		
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he Ho in 24 h he Fu	Medical	(Check only one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									e to the cause(s)	
Vith To 1	Σ	29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)  RES - 000  OCTOBER 4, \$2007										
j.		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)										
14		· ·	A A DAV,	m D		SIMAL	HOSPITI	L OF	BAL	Tir	MORE	
St Regist	ate rar	31. Date filed (Month, Day, Year)	32 gistr	ar's Signature	A	neall s						
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# Division or Vital Records, P.O. Box 68760

Baltimore, Maryland 21215-0036

**Physician** /Medical Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral r

4 Homicide

29a. Certifier

(Check only one)

Medical

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year)

29b. Signature and title of certifier

RES 000

10,03,2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MAY HARBOR

ALATT PR 31. Date filed (Month, Day, Year)

OCT 1 0 2007



DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Dav **Physician** 12:53 A M Catherine 2007 Ellena Graver October /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gilchrist Hospice Center Towson Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth
Months | Davs | Hours | Min. | (Month, Day, Year) Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Months 1 □ M 2 🖔 188-26-0820 75 Pennsylvania Director Мау 9, 1932 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at show 1 ☐ Yes 2 ☑ No Director MD HOward Laurel 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Pages 1 and 2 should be filed within 72 hours after death with Innent of Health and Mental Hygiene.
Int: If Item 27 Is marked other than "natural", or Items 23a or 3 o e must b 7930 Belgaro Road 20723 USA Funeral ral", or Items 2 14. Race - American Indian 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. ☐ Yes 2 Yes, Give 2**X** No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White Specify: Completed by 3 Widowed 4 XDivorced Year or Dates er than "nature the Medical E 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Vantage House Elementary/Secondary (0-12) College (1-4or 5+) Retirement Community Director of Housekeeping 12th Item 27 Is marked other other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Robert Lewis Johnson Gertrude Marie McHale ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anne Marie Graver/Daughter 409 Reagan Drive, Fairless Hills, PA 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If Ite any injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State West Arundel Crem. 10/5/2007 Odenton, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Donaldson Funeral Home, P.A. 313 Talbott Avenue, Laurel, MD mico M01103 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Came (Final disease or condition resulting in death)

a.

Due to (or as a consequence of): Approximate Interval Between Onset and Death Physician north /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical attending p for use as SE IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal dea 2 Fetal death 3 ☐ Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Day 5 Other (specify) signed by the a 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has e 2 certificate has irector, page 2 autopsy performe 2□ No 2 No 1 TYes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Pother (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မှ this After thi funeral 28a. Date of Injury 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? Certification: 5 Pending investigation (Month, Day Year) Injury 1 Natural 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director: A completely filled in by the f 2 ☐ Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of eath (Item 23a) (Type, Print) N. Charles St. Probts Md 2120x

State Registrar

31. Date filed (Month, Day, Year)

1 0 2007

DHMH 17 Rev 1/2001

6701

32. Registrar's Signature

07-07667 Donald Gray

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar		ate of D			Re	g. No. 200	7 3232
Physicia	an/	Decedent's Name (First, Middle,Last)					Date of Death     Month	Day Year r 30, 2007	3. Time of Death 2320 hrs
∕ledical Exami ⊶	ner	Donald Gray  4a. Facility Name (if not institution, give street and number)		AL 4	City, Town, or L	onalia- : f		r 30, 2007 4c. County of Death	23201115
		4a. Facility Name (if not institution, give street and number) 4114 Duane Avenue			altimore	ocalion of	Deaul	To. County of Death	
Funeral			yrs. last birt		Under 1 Year	If Under	24Hrs. 8. Date of Birt	h(MM/DD/YYYY) 9. Birti	
Director		214-44-7167 1 M 2 F 62			Months Days	Hours	May 24	Foreign	
	ŀ	Usual Residence of Decedent				J	1 1144 24	, +272	
v any			. City, Town						10d. Inside City Limits
Maryland 28a-f show any 1 at once	5	Md.	Ba1	timore					1 Yes 2 No
Maryl - 28a-1	Director	10e. Street and Number		10	of. Zip Code	_	10	g. Citizen of What Cour	
th the 23a or notifie		4114 Duane Ave.		140.00	2122.		-0.7.0	U.S.A	
ath wi	Funeral	11. Marital Status 1 Never Married 2 Married Armed Forces?					n? ( Specify Yes or No- Puerto Rican, etc.)	14. Race - Americ White, etc.	can Indian, Black,
ter de ", or i		3 Widowed 4 Divorced If Yes, Give Year	No	1 ☐ Ye	s 2 No	specify:		Specify: Whi	te
ours af	d by	15. Decedent's Education (Specify only highest grade complete	ed) 16a.	Decedent's l	Jsual Occupation	on (Give k	ind of work done	16b. Kind of Business/I	ndustry
6 72 hc nn "ng sal Ex	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)		3	of working life. I		·	Davison Che	micol Co
within iene.	μŽ	12		CHemi	cal Ope				micai co.
15-( filed al Hyg ed oth t, the		17. Father's Name (First, Middle, Last)  Leroy E. Gray			1	8.Mother's	Name (First, Middle, M Virginia E	,	
21215-0036 ould be filed within 7 Mental Hygiene. marked other than c event, the Medica	To Be	19a. Informant's Name/Relationship (Type, Print )	19	o. Mailing Ad	dress (Street	and Numl		ber, City or Town, State	, Zip Code)
MD 2 sholl h and 27 is		Leroy T. Gray (brother)						New York 1	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition	20b. Place		(Name of cem		Date	20c. Location - City or	
Pages eent of int: I		Burial 2 Cremation 3 Removal from State  Obnation 5 Other Specify:		•	ematory		10/10/07	Baltimore,	Md.
talti rmit spartm sporta sury o		21 In nature of Funeral Service Licensee	1		e and Address			eral Servic	
	_	Comon gramerous	li	400	l Ritch	ie Ba	altimore. M	d. 21225	
Physician /Medical		23a. Part I. Enter the disease or complications that caused the failure. List only one cause on each line.						est, snock, or neart	Approximate Interval Between Onset and
vaminer		Immediate Cause (Final disease or condition resulting in death)  a. Complications of cl Due to (or as a conseque		oholism a	and metasta	atic can	cer		Death
		Sequentially list conditions,  b							
	miner	if any, leading to immediate Due to (or as a conseque cause. Enter Underlying Cause	ence of):						
1	ल।	(Disease or injury that initiated events resulting in death) Last	ence of):						
ransit	al Ex	d.							
Division of Vital Records, P.O. Box 68760, within 24 hours after death.  To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	Medical	UNPENDED AMENDED							
3760, ificate be ig physic s the bur	⊓/Me	IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome o			death 3	Ectonic	pregnancy	23d. Date of delivery Month	/ Day Year
Box 687 e death certifit the attending	sician/	past 12 months?  4 Pregnant at time	of death		(Specify)	cotopic	p. 53.10.10)		-,
Bo he deat the att	Physi	1 Yes 2 No 9 Unknown g Unknown							
i, P.O. B ires that the d signed by the	by P	Part II. Other significant conditions contributing to death but	t not resultin	g in the unde	erlying cause gi	ven in Pai		obacco use contribute to s 2 No 3 ✓ Prot	
duires en sign	ted	Atherosclerotic cardiovascular disease					24a. Was		topsy findings available
cords law requi has been	Completed						autop		completion of cause of
tal Rection: The l	Con						1 🗸 Yes		es 2 No
Vital Rec ysician: The l his certificate l	Be	25. Was case referred to medical examiner?  Hospital: 1 Inpatient	2 ED/A	utpatient 3		of Death ( Other <sub>4</sub>	Check only one)  Nursing Home 5	Residence 6 ✓ Other	r Scene
of Villing Phys	- To	1 Yes 2 No The Impatient 27. Manner of Death 28a. Date of Injury		Time of Injur	<u> </u>	y at Work		how injury occurred	. Coone
on c anding ath. r: Af	tion	1 Natural 5 Pending (Month, Day, Year)		·		es 2			
Division of Vital Records, tal or Attending Physician: The law requir is after death.  al Director: After this certificate has been seled in by the funeral director, page 2 should t	fica	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury	- At home, fa	arm, street, f	actory, office bu	uilding, etc		Street and Number or Ru	ral Route Number, City
Division pital or Attent ours after death eral Director:	Certification:	4 Homicide determined (Specify)					or Town, S	otate)	
Division  To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the		29a. Certifier (Check only 1 Certifying Physician: To the best of my known of the best of my known on	-						
To the within To the complete	Medical	one) 2 Medical Examiner: On the basis of examina and manner stated.	ation and/or i	rivestigation			Juireo al the time, date		
	2	29b. Signature and title of certifier	$\Omega$		29c. License O.C.N			29d. Date signed (Mo	пш, рау, теаг)
J VI		June Istery mi	//- 52 :		0.0.1	···-·		35,525, 1, 2007	
MI		30. Name and address of person who completed cause of death Tasha Greenberg MD. Assistant Medical E		111 Pe	enn Street, E	Baltimo	re, MD 21201		
	tate	31. Date filed (Month, Day, Year) 32. Registrar's S		1	w.				
Regis		OCT 1 0 2007 filesen	1 10	Sport	EL)				
DHMH 17 Rev 1/2	2001	OCA4E	OF	RIGINAL					

5. Social Security Number

212-26-674

Usual Residence of Decedent

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Baltimore

Days

If Under 1 Year | If Under 24 Hrs.

14. Race - American Indian

Black, White, etc.

Specify:

State

9. Birthplace (State or Foreign

10d. Inside City Limits

1 Thes 2 No

8. Date of Birth (Month, Day,

1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month gene 10 017 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility came (If not institution, give street and number) NI

7. Age (In yrs. last birthday)

Kehabilitation Extended Care

125M 2□F

6. Sex

/Medical Examiner

Director

Funeral

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Completed

Be

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Examiner

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Medical

29a, Certifier

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

0CT 1

and address of person who completed cause of death (Item 23a) (Type, Print) ah, M.D. 3900 Lock Raven Boxlevaro

32 Registrar's Signature

**Funeral** Director

or 28a-f show

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygelner. Department if Hean 23s or 28s-f show Important: If Hean 27 Is marked other than "natural", or items 23s or 28s-f show any InJury or other traumatic event, the Medical Examiner must be notified at 2 should be filed within 72 hours after on and Mental Hygiene.

Baltimore, Maryland 21215-0036

**Physician** /Medical **Examiner** 

as the burial-transit neral Director: After this certificate has been signed by the attending physician and filled in by the funeral director, page 2 should be detached for use as the burial-trar To the Hospital or Attending Physician: death. after death

Division or Vital Records, P.O. Box 68760

10c. City, Town or Location 10a. State 10b. County imor 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 12. Was Decedent Ever in U.S. Armed Forces? 1 Deceded a 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1452 1 ☐ Yes 2 ☐ No 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 80 WIFE amondson Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 □ Cremation 3 ☐Removal from State 4 Donation 5 Dother (Specify) rarreson 22. Name and Addre of Facility of Funeral Service Licensee lace MCU ase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, e. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) arcinoma nonsmo cell ( Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes Completed 24a. Was an autopsy performed? 1♥ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 3□ DOA 2 ER/Outpatient Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manfier of Death 28c. Injury at Work? Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide

でい Balto, md, 21223 20c. Location - City or Town, State Approximate Interval Between Onset and Death 4 Months 23d. Date of delivery Month Day 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Wonknown 24b. Were autopsy findings available prior to completion of cause of deaty?

1 ▼Yes 2 No

29d. Date signed (Month, Day, Year)

2007

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State Registrar

within 24 hours a To the Funeral C

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

Oltio)

Baltimore, Maryland

Registrar
DHMH 17 Rev 1/2001

State

30. Name and audin

31. Date filed (Month

DANIEUE DOBERMAN.

0 2007

son who completed cause of death (Item 23a) (Type, Print)

3 Registrar's Signature

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D 64395

NCHAPLES ST, SUITE 209, BACTMITE, MD 21204

OCTOBER 6,2007

Division or Vital Records, P.O. Box 68760

Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been stoned by the attendion abusinan and burial-tran the. cate has ours after death.
nerai Director: A
filled in by the fu

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician

/Medical

Examiner

**Funeral** 

Director

28a-f show

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the Medical

item 27

Department of important: If it any injury or conce.

Physician

/Medical

Directo

Funeral

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Be Completed

2

death with the Maryland

Baltimore, Maryland 21215-0036

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IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf pregnancy  1	pic pregnancy or (specify)	<u> </u>	23d. Date of delivery Month Day Year
Part II. Other significant conditions	contributing to death but not resulting in the underly	ing cause given in Part I.	23e. Did tobacco	use contribute to the cause of death?
Hypertens	ifficiency		1 ☐ Yes	2ĒNo 3☐ Probably 4☐Unknown
Hypertens	ion		24a. Was an autopsy performed?	
25. Was case referred to medical examiner?		26. Place of Deat	h (Check only one)	
1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3	□ DOA Other: 4 □ Nursing Ho	me 5 Residence	6 □Other (Specify)
27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident Investigation	28a. Date of Injury (Month, Day Year) 28b. Time of Injury	28c. Injury at Work?	28d. Describe how in	
3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of injury - At home, farm, street, fa building, etc. (Specify)	ctory, office	28f. Location (Street City or Town, Sta	and Number or Rural Route Number, tte)
29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exar	nysician: To the best of my knowledge, death occu niner: On the basis of examination and/or investig and manner stated.	urred at the time, date and place, ation, in my opinion, death occur	and due to the cause red at the time, date a	(s) and manner as stated. ind place, and due to the cause(s)
29b. Signature and title of certifier	0	29c. License number	29d. D	Date signed (Month, Day, Year)
( ) Lin X	Strain Ard	D44715	10	1.8.07

ST PAUL TOACT MAD 21202

State Registrar

FYKNCIS X. 31. Date filed (Month, Day, Year)

OCT 1 0 2007

32 egistrar's Signature

e and address of person who completed cause of death (Item 23a) (Type, Print)

STY AM, MO 301

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 29, 2007 **Physician** Dorris Mae Harper Hill September 5:00 PMM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Hospital Cheverly Prince George's If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Funeral Months 1 □ M 2 🔯 80 Ohio Director 5-12-1927 268-24-9808 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show event, the Medical Examiner must be notified at 1X Yes 2 No Director Cuvahoga Maple Heights 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ö 23a 44137 6000 Dunham USA Funeral or items 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify Specify: Black ò 3 ⊠ Widowed 4 □ Divorced Year or Dates 'natural" Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than, Cleveland Elementary/Secondary (0-12) College (1-4or 5+) Board of Education 12 Teacher other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be if Health and Mental I ပ Bee Harper Evelyn McClelland 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Celeste Hill Clark/Daughter 4407 Sutherland Circle, Upper Marlboro, MD 20772 20b. Place of Disposition (Name of cemetery, crematory or other place)
Cleveland Memorial
Gardens 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If ite
any injury or ot 1 Burial 2 □ Cremation 3 □ Removal from State 10/5/07 Highland Hills, Ohio 4 ☐ Donation 5 ☐ Other (Specify) E. F. Boyd & Son Funeral Home 21. Sign ure of F neral Service Licens 22. Name and Address of Facility 2165 E 89th Street, Cleveland, Ohio muce anner 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Advanced /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine or Attending Physician: The law requires that the death certificate be executed A S Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 physician Physician/Medical the i as IF FEMALE: yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) the 9 ☐ Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of certificate has death? 1 ☐ Yes 2∏ No 1∐ Yes 2X No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No P 1 🔀 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t Certification: 5 ☐ Pending investigation Injury 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 29a. Certifier 1 ី CertifyIng Physiclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

the

State

Registrar

ALLYEN-DAMSON MD. 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

3001 Hospital Dr., Cheverly, MD 20785 32. Registrar's Signature

and manner stated.

OCT 1 0 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

D0505

29d. Date signed (Month, Day, Year)

SEPTEMBER 29, 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 32330 Reg. No. 2007 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Dav Year **Physician** Sept 28 Lile 2007 Warren /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner tospita EIKton Under 1 Year If ,QC1 nion 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. Hours Min. 9. Birthplace (State or Foreign Country) **Funeral** Days 1**3** M 2□ F Months Usual Residence of Decedent Director 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County ral", or items 23a or 28a-f show Examiner must be notified at 1 Pres 2 No Director Elktor eci 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 16916 68 toita by Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 1 12 Yes 2 □ No Army If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: 3 ☐ Widowed 4 Divorced "natural", Completed traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 12 should be filed within 7 h and Mental Hygiene.
7 is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) Manu Facturer Assembler 19 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) To Be Marvin Pages 1 and 2 should nent of Health and Mer Hamm Hn mil be 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health in the Sharon 20b. Place of Disposition (Name of cemetery, crematory or other place) Elkton, MD 21921 20c. Location - City or Town, State Date 20a. Method of Disposition. Important: If it any Injury or o once. 1 ☐ Burial 2 Defemation 3 Removal from State remater y 5 ☐ Other (Specify) 10-12-07 4 ☐ Donation etro ( Funer Service Licensee 22. Name and Address Facility II.AM 1232 Midualley Dr. Jessep, PA 184134 23a. Part1. En shock, o Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Basaloid Carcinoma of Immediate Cause (Final Metastatic Physician unknur disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the death certificate be executed burial-transi and Due to (or as a consequence of) physician s the burial Physician/Medical use as ding IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? for u 3 Ectopic pregnancy Month Day Year 4□Pregnant at time of death
9□Unknown 5 ☐ Other (specify) signed by the a 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ 1 Yes 2 No 3 Probably 4 Unknown cate has been si page 2 should t Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Yes 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ပ 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident

Box 68760 P.O. Division or Vital Records,

Baltimore, Maryland 21215-0036

Certification:

Medical

State Registrar

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director,

29a. Certifier

6 ☐ Could not be 3 ☐ Suicide determined 4 ☐ Homicide

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

29c. License number

Scale 8B

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Elpton

29b. Signature and title of certifi Saelider S MI

20023322

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 118 North 81 S. S SACHDEN MU

31. Date filed (Month, Day, Year)

32. Paistrar's Signature

DHMH 17 Rev 1/2001

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		•	1 - State of Maryla Registrar	-	rtment of H tificate of L		ental Hygic Rec	ene g. No. 2007	32331
Ī	Physicia		1. Decedent's Name (First, Middle, Last)  WAYNE WELLINGTON	HOI	_		2. Date of Death	Day Year 75 100.7	3. Time of Death
je i	/Medic Examin		4a. Facility Name (If not institution, give street and number)	1,00		Location of Death	, ,	4c. County of Death	10,01
			Howard County General Hospita		Columbi			Howard	
	Funeral Director		5. Social Security Number 5.78 − 3.8 − 0.770	rrs. last birthday) 6	If Under 1 Year  Months Days	Hours Min.	B. Date of Birth (Month, Day, 1) May 25	Year) Cou	place (State or Foreign ntry) ington, DC
	yland low at			City, Town or Loc	ation				10d. Inside City Limits
	e Mar Ba-f sh utified	Director		Laurel					1 □Yes XXNo
	with th		10e. Street and Number		10f. Zip Code		10	g. Citizen of What Cou	ntry?
	leath	Funeral	6213 Roblynn Road  11. Marital Status  12. Was Decedent Ever in	n U.S.   13. W	20707 /as Decedent of Hi	spanic Origin? (Spec In, Mexican, Puerto R	ifv Yes or No-	USA 14. Race - Ameri	can Indian,
036	be filed within 72 hours after death with the Maryland ital Hygiene. d other than "natural", or items 23a or 28a-f show event, the Me. Ical Examiner must be notified at	۾	Armed Forces?  1 □ Never Married 2 □ Married   1 ☒ Yes 2 □ No   1 ☒ Yes 3 ☒ Widowed 4 □ Divorced   Year or Dates:		Yes, specify Cuba  ☐ Yes 2  ☑ No		ićan, etc.)	Black, White,	
1215-0036	"natur	eted	15. Decedent's Education (Specify only highest grade completed)	16a. Deced	ent's Usual Occupa	ation during most of working	7	6b. Kind of Business/Ir	dustry
212	l withir jiene. r than the M	Completed	Elementary/Secondary (0-12) College (1-4or 5+) 12th 2	1	cial Ager			NSA	
Maryland 2	0 = 0 5	BeC	17. Father's Name (First, Middle, Last)			18. Mother's Name (	First, Middle, M.	aiden Surname)	
yla	2 should be and Mental Is marked o aumatic eve	၉	Frank Hancock Holt			Arbutus			
Z Z	0 0 0		19a. Informant's Name/Relationship (Type. Print)  Matthew G. Holt/Son			and Number or Rural ace, Laure		City or Town, State, Zi	o Code)
	t ar Hea em ther		20a. Method of Disposition 20th		ition (Name of atory or other plac		<del></del>	20707 Oc. Location - City or T	own, State
Ē	Pages nent of ant: If It ant: or o		PE Burial 2 Cremation 3 Perioval from State		6 Cemeter	1	/2007	Laurel, MD	
Baltimore,	permit. Page Department of Important: If any Injury or once.		21. Signature of Funeral Service Lioutisee M00			ss of Facility Dona t Avenue,		Funeral Hom , MD 20707	
	Physician and physician and physician and physician and physician and step the purial-transit	edical Examiner	23a. Part1. Enter the disease or complications that caused the dishock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a constitution of the cause). Due to (or as a constitution of the cause). Due to (or as a constitution of the cause). Due to (or as a constitution of the cause).	SMALL sequence of):	r the mode of dyin	g, such as cardiac or	CANC	ER .	Approximate Interval Between Onset and Death
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J.	w requires that the bear signed by should be detac	þ	Part II. Other significant conditions contributing to death but not	resulting in the un	derlying cause give	en in Part I.	23e. Did toba	acco use contribute to	he cause of death?
Š	v requi	eted	N 0	-	<del></del> .		-		
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	ysiclan: is certific director,	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 20 No Hospital: 1 ☐ mpatient 2	P ☐ ER/Outpatient	3 DOA Othe	26. Place of Death (		nce 6 Other (Speci	6.1
יסר	ding Phys h. After this funeral di	-	27. Manner of Death 1 Datural 5 □ Pending (Month, Day Year,	28b. Time of	28c. Injury Work			w injury occurred	(1)
UIVISION	he or:	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of injury - Abuilding, etc. (Spe	t home, farm, stre	M 1□'	Yes 2 □ No	of. Location (Stree City or Town,	eet and Number or Rur State)	al Route Number,
_	To the Hospital or Att within 24 hours after de To the Funeral Direct completely filled in by the	edical Ce	29a. Certifier (Check only 2 ☐ Medical Examiner: On the basis of exam	knowledge, death	occurred at the timestigation, in my o	ne, date and place, ar	nd due to the car	use(s) and manner as	stated.
	o the lithin 2, or the lithin 2, or the lithin 2, or the lithin 2, or the lithin 2, or the lithin 3, or the	Medi	one) and manner stated.  29b. Signature and little of certified.		29c. License			d. Date signed (Month,	``
)	F3F8		1////	M					
0	25+1		30. Name and address of person who completed cause of death (I	tem 23a) (Type, F	rint)  HLP F	PATUXA	nt Pk	Cuy Col	21044 mb ia mo
	Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signature of the State of the Sta	gnature	,			J	
			IIII T O LOO.						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registrar	State of Ma	•	epartmen Certificate				ene 20	7	32332
	Physici	an	1. Decedent's Name (First, Middle, La	11	MPH	RIE	<		2. Date of Death Month	Dav	Year 2007	3. Time of Death
	/Medic Examin		4a. Fecility Name (If not institution, giv	e street and number)	50.T			ocation of Death	October		of Death	3.0/1
	Funeral Director		5. Social Security Number 217-38-4262 6. 5	URS HO	(In yrs. last birth 63 Yı	Months		T M O If Under 24 Hrs. Hours Min.	8. Date of Birth	943		ace (State or Foreign
	D		Usuel Residence of Decedent  10a. State 10b. County	· · · · · · · · · · · · · · · · · · ·	10c. City, Town	or Location					10	d. Inside City Limits
	Maryli 9-f sho	tor		/A			Baltir	more			N.	1 Yes 2 □ No
	with the ta or 284	Direc	10e. Street and Number 3138 Presstman Street			10f. Zip	Code	21216	10g	g. Citizen of	What Count U.S.A.	ry?
9036	be filed within 72 hours after death with the Maryland tal Hygiene. Id other than "natural", or items 23a or 28e-f show event, Ite Medical Exercities must be notified at	by Funeral Director	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 N If Yes, Give Year or Dates:			х.	panic Origin? (Sp Mexican, Puerto Specity:	ecify Yes or No- Rican, etc.)		e - America ck, White, e y:	
21215-0036	within 72 h iene. than "natu the Madical	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)		16a. C	Decedent's Usua Give kind of wor life. DO NOT us	al Occupation de la Companie de la C	on ring most of work <b>Driver</b>	ing 16	Sb. Kind of B	usiness/Ind altimore	•
land 2	should be filed within nd Mental Hygiene marked other then	To Be Co	17. Father's Name (First, Middle, Last Robert	lumphries			18	8. Mother's Nam	e (First, Middle, Ma Sallie	niden Suman Harris	ne)	
Maryland	nd 2 shou alth and N 27 is mar		19a Informant's Name/Relationship Lillian Humphries Wife	Туре, Print)	19b. I	Mailing Address 3138 Pres	(Street and stman	d Number or Run Street Baltim	al Route Number, Clore, Maryland	21216	State, Zip	Code)
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked any injury or other traumatic evonce.		20a. Method of Disposition  1 A Burial 2 Cremation 3 C  4 Donation 5 Other (Speci		20b. Place of C cemetery,	Disposition (Nan crematory or of ing Memor	ne of ther place) ial Park	1	Date 20 0/11/07	oc. Location Win	City or Tov dsor Mill	
Balti	permit. Departn Imports any inju		21. Signature of Funeral Service Lice	nsee ( ) He	575	22. Name ap ESI 130	d Address ep Brot 00 Euta	of Facility hers Funera w Place Bal	al Service, P. A	217		
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Division	or Attending after death. Director: After in by the fune	Certification;	2 Accident investigation 3 Suicide 6 Could not be determined	OB Diagn of Inju	ry - At home, fam	М	1 □ Ye	s 2 🗆 No	28f. Location (Stre City or Town,		er or Rural	Route Number,
۵	Hospital	Medical Cer	29a. Certifier 1 Destrifying Pi	hysician: To the best of miner: On the basis of and manner sta	examination and/	death occurred for investigation,	at the time, in my opin	, date and place, nion, death occur	and due to the cau red at the time, date	ise(s) and m e and place,	anner as sta and due to	ated. the cause(s)
	To the within 2 To the complex	Mec	29b. Signature and title of certifier	P. Cru	ZM		License n		1	1. Date signe		-
	5		30. Name and address of person who	completed cause of d	ath (Item 23a) (T	ype, Print)	E	POH.	5 a SECO	urs	He	OSPITAZ
	Sta Registr		31. Date filed (Month, Day, Year)  OCT 1 0 2	32. Registra	r's Signature	breste					·	
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DHMH 17 Rev 1/2001

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State of Maryland / Department of Health and Mental Hygiene

32333 Certificate of Death 3. Time of Death 2:00 p 1. Decedent's Name (First, Middle, Last) 2. Date of Death Oct 5, 2007 Year Month Evelyn Adell Hackett **Physician** /Medical 4b. City, Town, or Location of Death 4c. County of Death Baltimore 4a Facility Name (If not institution, give street and number) Examiner Baltimore Manor Care Health Services If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Date of Birth (1001) 24, 1947 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 M 2 F Days 218-05-5565 89 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours efter death with the Maryland Department of Heath and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 28a or 28a-f show any injury or other traumatic event, it a Modical Evantment in the profile. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Maryland Baltimore N/A 1 Yes 2 No Director 10f. Zip Code 10g. Citizen of What Country? U.S.A. 10e. Street and Number 21207 2121 Windsor Garden Lane Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 D No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No Black Baltimore, Maryland 21215-0020 Specify: Specify: þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Own Home Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Sumame)
Bessie Chase 17. Father's Name (First, Middle, Last) Be Charles Haves 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6747 Brookmont Drive Baltimore, Maryland 21207 Edward Hayes Son 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 10/12/07 Owings Mills, Md. Garrison Forest Veterans Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217 21. Signature of Funeral Service Licenses 23a. Part1. Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) MULTIPLE SCLEROSIS Examiner Due to (or as a consequence of): Examiner led by the attending physician end detached for use as the buriel-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Division of Vital Records, P.O. Box 68760-Completed by Physician/Medical Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? certificate has been signed by irector, page 2 should be detac 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown CARDIOVASCULAR 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 1 No 1 🗆 Yes 1 ☐ Yes 2 ☐ No Hospital or Attending Physician:
124 hours efter death.
 Funeral Diractor: After this certifical letely filled in by the funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 ☐ No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Matural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \ Homicide 10 rtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one) To the I within 2 To the F 29b. Signature and title of certifier 29d. Date signed (Month. Dav. Year) 29c. License number D0059107 10-8-2007 m.D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) REISTERSTOWN MD 21136 BUSINESS CENTER DIRIVE UMA 210 31. Date filed (Month, Day, Year) 32. Registrar's Signature State OCT 1 0 2007 Registrar Moure & Speeds

Funeral Director

	1. Decedent's Name (First, Mic		7)	11 1101 111		2. Date of De Month		Year	3. Time of Deat				
an al	BETTE	REGIN		HENRY		1		2007 Year					
er	4a. Facility Name (If not institut		er)		or Location of Death	I	4c. (	County of Dea	ath				
	MANOR CARE  5. Social Security Number		Age (In yrs. last birthda		OMAC  If Under 24 Hrs.	8. Date of Bi	rth	9. Bi	rthplace (State or For				
	165-10-7698. Usual Residence of Decedent		88 Yrs.	Months Days	Hours Min.	(Month, D		C	JERSEY				
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ctor	MD		POTOM	IAC					1 X Yes 2□				
Director	10e. Street and Number			10f. Zip Code			10g. Citiz	en of What C	country?				
	10714 POTOM				854			J.S.A.					
Funeral	11. Marital Status	12. Was Deceder	nt Ever in U.S. 13	B. Was Decedent of I If Yes, specify Cub	Hispanic Origin? (Sp ban, Mexican, Puert	pecify Yes or No o Rican, etc.)	0- 1	<ol> <li>Race - Am Black, Wh</li> </ol>	erican Indian, ite, etc.				
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70 E	CHRISTOPHER	J.	HENRY,		ELIZA			SHA					
	19a. Informant's Name/Relatio	onship (Type. Print ${ m GUA}$	i i										
	CHRISTOPHER	G. HOGE -			ISLAND				DC 20036				
	20a. Method of Disposition 1 ☐ Burial 2 ②Crematio 4 ☐ Donation 5 ☐ Other	on 3 Removal from Sta r (Specify)	cemetery c	position (Name of rematory or other pla LE CREMA	ATORY 10	Date -2-07	1	•	r Town, State				
	21. Signature of Funeral Servi	ioe tice see						•	FUNERAL MD 212				
	23a. Part1. Enter the disease,	, or complications to at caus	sed the death. Do not e					THORE	Approximate				
	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final												
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	disease or condition resulting in death)  a. Detite ITCIa  Due to (or as a consequence of):												
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2007 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2007 Oct. Physician 01, Emil Robert Illian 1514 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Upper Cheapeake Hospital Bel Air Harford If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month Day, Year) 54 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours Country) 5.3 216.58.0940 Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits ortant; If Item 27 is marked other than "natural"; or Items 23a or 28a-f show Injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director MD Harford Abingdon 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4001 Pulaski Highway 21009 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 <del>DNo</del>
If Yes, Give
Year or Dates: 1 ☐ Never Married 2 ☐ Married White 1 ☐ Yes 2 ☐ Mo Specify. Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Mechanic Automotive permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Item 27 is marked othe any Injury or other transcent 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Otto Henry Illian Mary Katherine Polan 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4001 Pulaski Highway, Abingdon, MD 21009 Sherry Illian 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Fernation 3 ☐ Removal from State Chesapeake Crem. 10.05.07 Beltsville, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Cremation And Funeral Balto 21. Signature of Funeral Service Licensee Alternatives 8717 Green Pastures Dr. MD 23a. Part1. Ent.r the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) KEPHALOPATTA **Physician** 5 DAYS /Medical Due to (or as a consequence of): Examiner ARDIAC Sequentially liet conditions; if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Due to (or as a consequence of): attending physician Physician/Medical 1ELE MONIA IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director; After this certificate has be 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No 24a. Was an autopsy performed? 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 No 1 🔀 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Injury 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 26344

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State Registrar 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

low I Sparke

30 Warmeland address of person who completed cause of death (Item 23a) (Type, Print) 500 Upper MTRICHT GORNY, MD COME BELATE MARY LAND

ORIGINAL

### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2007 32336 Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Lest) 2. Dete of Death Month Dey Year Physician 3 2007 Doris Johnson Oct. 7:35 PM /Medica Examine

**Funeral** Director

permit. Peges 1 and 2 should be filed within 72 hours after death with the Marylend Dapartment of Haaith and Mental Hygiene. important: If item 27 is marked other than "natural", or items 23a or 28e-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020 **Physician** 

Weateal Examiner To the Hospital or Attending Physician: The law requiras thet tha death certificete be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attanding physician and completely filled in by tha funerel director, paga 2 should be detached for usa as the burial-transit Division of Vital Records, P.O. Box 68760,

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	O	Eddie L.	Best						E	Easter	Buckrh	am				
	-	19a. Informant's Na	me/Relations	hip (Type, Print)		19b.	Mailing A	ddress (Stree	et and f	Number or F	Rural Route Nun	ber, City	or Town,	State, Z	Zip Code)	
		Samuel J	Johnson	/Husband		21.	30 Br	ooks I	Driv	re #40	8 Fore	stvi	11e,	MD	20747	
		20a. Method of Disp	osition		20b. F	Place of	Dispositio	on (Name of ory or other p	niaca)		Date	20c. L	ocation -	City or	Town, State	
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DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** William O(muson WOLL 10 05 2007 07:30M /Medical 4c. County of Death Facility Name (If not institution, give street and number) 4h City Town or Location of Death Examiner BAH: MORE VA RCHAB: Litan Extended CARE BALTIMURE 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral №** M 2□ F Months Hours 213-32-5636 Director 4-11-1934 Md Usual Residence of Decedent with the Maryland 10a. State 10h. County 10c. City, Town or Location 10d. Inside City Limits iral", or items 23a or 28a-f show Examiner must be notified at 1XYes 2 No Md. Director NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1402 McCulloh Street 1st Floor Funeral 21217 death v USA 12. Was Decedent Ever in U.S. Armed Forces? American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or ite may injury or other traumatic event, the Medical Examine one. 1 M Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ Specify: Black 3 ☐ Widowed 4 ☑ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th grade 17. Father's Name (First, Middle, Last) Disabled NA 18. Mother's Name (First, Middle, Maiden Surname) Be William P Johnson Helen Maiden 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Daughter 5753 Hazelwood Circle Apt. B.

20b. Place of Disposition (Name of cemetery, crematory or other place) Patricia Johnson 20a. Method of Disposition Baltimore, Md. 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Md. Vet. Cem. 10-11-07 Crownsville, Md. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility March F.H. East 1101 E. North Ave., Baltimore, Md. an 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Errier Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed Exami physician and s the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. Physician/Medical as attending IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy ō in the past 12 months? 1 ☐ Yes 2 ☐ No Month Vear 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy 24b. Were autopsy findings available prior to completion of cause of cate has t performe death? 2 1No 1∐ Yes 2 No funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 ☐ Yes Other: 2 No Certification: To 1 🗌 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation s after death.

I Director: Al 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral I

completely filled filled To the Hospital 1 Decrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) 29b. Signature and title of ertifice 29c. License number 29d. Date signed (Month, Day, Year) 097804 mee 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MROWIEC 3900 Blvo Baltinove MD 21218 Loch Raven 31. Date filed (Month, Day, Year) State

Registrar DHMH 17 Rev 1/2001



07-07788 Jerry Johnson

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2007 32338
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JIIISOII			ificate of Death	Reg. No	
<sup>¬</sup> hysicia		egistrar . Decedent's Name (First, Middle,Last)		Date of Death     Month Day	3. Time of Death
Exami	ner	Jerry John		Month Day October 5, 200	)7 2220 1113
	4	a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death		c. County of Death  Charles
		Northbound Route 210 North of Maryland 227	Bryans Road		
Funeral	5	. Social Security Number 6. Sex 7. Age (In yrs. las		_	//DD/YYYY) 9. Birthplace (State or Foreign
Director		578-68-5973   1XM 2 F   56	Months Days Hours Min.	Dec 12,	1950 Washington, Do
	-	Jsual Residence of Decedent			
any	<b>—</b>	Oa. State 10b. County 10c. City, T	Fown or Location		10d. Inside City Limit
<b>*</b>			ie		1 X Yes 2 N
Aaryland 28a-f show 1 at once,	호	MD Prince George Bows  [De. Street and Number]	10f. Zip Code	10g. C	itizen of What Country?
Mary 28a	Director			7.7	S.A.
and 2 should be filed within 72 hours after death with the Maryland eath and Mental Hygenes again and are season as a season a	莒	12104 Raritan Lane	20715 S. 13. Was Decedent of Hispanic Origin? (S		14. Race - American Indian, Black,
ms 2		11. Marital Status 12. Was Decedent Ever in U.S Armed Forces?	If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	White, etc.
death or ite	5	1 Never Married 2 Married 1 Yes 2 X No	OF No specific		Specify: White
al de	by F	3 Widowed 4 X Divorced If Yes, Give Year or Dates:	1 Yes 2 X No specify:  16a. Decedent's Usual Occupation (Give kind of	work done 16h	o. Kind of Business/Industry
atur		13. Decoderic Education (Epistry 7)	during most of working life. DO NOT use ret		,
72 h	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)		-	Repossession
ithin ne. Tedio	입	12	Recovery Agent	e (First, Middle, Maid	
ed w lygie othe	3[	17. Father's Name (First, Middle, Last)			,
uld be filed withi Mental Hygiene. marked other the cevent, the Med	Be	Ernest Johnson, Sr.	19b. Mailing Address (Street and Number or	ae Barry	City or Town, State, Zip Code)
Pages I and 2 should be filed within 72 hours after dealt and of Health and Mental Hygiene. I and: If fiem 27 is marked other than "natural", or ite or other traumatic event, the Medical Examiner must or other traumatic	입	19a. Informant's Name/Relationship (Type, Print )			
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l and Heal iten	[	20a. Metriod of Disposition	crematory or other place)	50.0	,
ages nt of tt: 10		T-7	Arundel Crematory Oc	t 9, 07	Odenton, Maryland
permit. Pages I and 2 shoul Department of Health and M Important: If iten 27 is m injury or other traumatic		4 Donation 5 Other Specify: W.  21. Signature of Funeral Service Licensee	22. Name and Address of Facility Donaldson Funeral	Home. P.A	Α.
Depa Impo	۱ ۱	MOO:	773 313 Talbott Ave.	Laurel, Ma	aryland 20/0/-4389_
ysician	_	23a Part I. Enter the disease, or complications that caused the death	. Do not enter the mode of dying, such as cardiac	or respiratory arrest,	shock, or heart Approximate Intel
Medical		failure. List only one cause on each line.			Death
xaminer		Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of the condition resulting in death)	of):		
		b			
	-	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of	of):		
	in	cause. Enter Underlying Cause			
by -	Examiner	(Disease or injury that initiated events resulting in death) Last	of):		
cuted nd transi	<u>u</u>	d			
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icate be executed physician and the burial - transit	ě	IF FEMALE: 23c. If yes, outcome of preg			23d. Date of delivery  Month Day Year
rtific ling p	sician/	23b. Was decedent pregnant in the past 12 months?	2 Fetal death 3 Ectopic preg	nancy	Month Bay
e death certific the attending p	ië	4 Pregnant at time of the	eath 5 Other (Specify)		
e des the s	Phy	Part II. Other significant conditions contributing to death but not	resulting in the underlying cause given in Part I.	23e. Did toba	acco use contribute to the cause of death'
nat th	by P	Part II. Other significant conditions contributing to death but not	resulting in the underlying earlier gives in	1 Yes	2 No 3 Probably 4 Unkno
es t	9	) <del></del>		24a. Was an	24b. Were autopsy findings avai
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requir been si		_			
e law requir thas been si	du			perform 1 <b>V</b> Yes 2	No 1 Yes 2 N
The law requires that the death certificate be executed frame here is greed by the attending physician and roace 2 should be clearched for use as the burial - transi	Completed	Or War see referred to medical	26.Place of Death (Che	1 <b>Y</b> Yes 2	No 1 Yes 2 N
cian: The law requir certificate has been si	Be Comple	25. Was case referred to medical examiner?	Other	1 Yes 2 ck only one)	No 1 ✓ Yes 2 N esidence 6 ✓ Other: Scene
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**ORIGINAL** 

19a. Informant's Name/Relationship (Type. Print) Loretta Griest 1315 Dale Rd. Pasadena, Md. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Jersey Cemetery 10/5/07 21. Signature of Funeral Service Licensee amerousk Immediate Cause (Final Physician disease or condition resulting in death) /Medical (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner attending physician and I for use as the buriat-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a 9□Unknown 9 Dlinknown been signed to should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 Completed 24a, Was an s certificate has be lirector, page 2 s To the Hospital or Attending Physician: in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 No 2 ER/Outpatient 3□ DOA ဥ 1 🔲 Inpatient After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification; 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident fiter death 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral C 29a. Certifier Medical and manner stated. 29c. License number 10 30. Name and address of berson who completed cau e of death (Item 23a) (Type, Print orbat Registrar's Signature 31. Date filed (Month, Day, State Registrar DHMH 17 Rev 1/2001 **ORIGINAL** 

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 8:00 AM Johnson October | 2007 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Pasadena Under 1 Year | If Under 24 Hrs. 7691 Oak Lane <u> Anne Arundel</u> Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 Year Days 8. Date of Birth (Month, Day, Year) Hours 1 □ M 2 🗷 F 215-28-9146 July 29, 1930 Pa. Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits Md. Anne Arundel Co. Pasadena 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7691 Oak Lane 21122 U.S.A. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No 3 ☐ Widowed 4 ☑ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Sales Clerk Department Store 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Alex Hyatt Daisy <u>Lytle</u> 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21122 20c. Location - City or Town, State Confluence, Pa. 22. Name and Address of Facility Gonce Funeral Service P.A. 4001 Ritchie Hgwy. Baltimore, Md. 21225 23a. Part1. Enter the dis sour or complications that caused the death. Do not enter the mode of dying, such as cardiac y respiratory arrest, shock, or heart failure y list only one cause on each line. 23d. Date of delivery Month Day Year 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? Other: 4 Nursing Home 5 Desidence 6 Other (Specify) 28d. Describe how injury occurred Location (Street and Number or Rural Route Number, City or Town, State) 1 Detrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 32340 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** Virginia Jones 2:45 p /Medical Oct 4, 2007 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Ellicott City Health & Rehabilitation Center Ellicott City Baltimore If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Age (In yrs. last birthday **Funeral** 1□M 254F Months Director 213-14-8592 Mar 25, 1912 Virginia Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show ortant: If item 27 is marked other than "natural", or items 23a or 28a-f shov Injury or other traumatic event, the Medical Ex iminer must be notified at 1XXes 2□No Director Maryland N/A Baltimore 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 3219 Division Street 21217 Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 72 hours after 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 2210 1 Never Married 2 Married 3 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗷 No Specify. **≙** Specify. 3 Widowed 4 □ Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any injury or other traumment. Elementary/Secondary (0-12) College (1-4or 5+) Hotel Maid 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James Fitzgerald Margaret Hawkins ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Father Robert Kearn 1546 North Fremont Avenue Baltimore, Maryland 21217 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 12 Nurial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Dother (Specify) 10/11/07 Baltimore, Md. **New Cathedral Cemetery** 21. Sign tur of Funeral Service Don 22. Name and Address of Facility Estep Brothers Funeral Service, P. A.

1300 Eutaw Place Baltimore, Md 21217

23a. Part1. Enter tife disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) EREBRO VACCUL **Physician** THEROSCUPROTIC /Medical Due to (or as a consequence of) Examiner Esquentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine burial-tran Due to (or as a consequence of): P.O. Box 68760 attending physician Physician/Medical for use as the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4□Pregnant at time of death 5 Other (specify) ed by the a detached f 9 Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Vital Records, Completed by PERTENSION 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should has been ENAL 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No autopsy certificate Physiclan: funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 20 No Other: ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) within 24 hours after deaun.

To the Funeral Director; After this manuately filled in by the funeral di Division or 27. Manper of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) L1 ☐ Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 6 🖖 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) llarin 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SMITH AVE ASN EEM SUITE 203 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 0 2007 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner If Under 24 Hrs. 8. Date of MEMORIAL tOSPITAL If Under 1 Year 5. Social Security Number 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 6. Sex **Funeral** Days 1□M 2XF Months 5-74-40 **Director** Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mertal Hyglene. and I filem 27 is marked other than "natural", or items 23a or 28a-f show ant; if item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No by Funeral Director MARYLAND 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status American Indian. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗷 No 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) THGRADE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1X Burial 2 ☐ Cremation 3 Demoval from State 4 ☐ Donation 5 ☐ Other (Specify) 10-16 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory an st, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) ROM /Medical Due to (or / a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner sate has been signed by the attending physician and pege 2 should be detached for use as the burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 5 Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 2 🗌 No 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1∐ Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner' 1 Inpatient Other: 1 🗌 Yes 3□ DOA Medical Certification: To 2 ER/Outpatient 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 ☐ Accident (Month, Day Year) Injury 5 Pending M 1 ☐ Yes 2 ☐ No investigation within 24 hours after death To the Funeral Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MEMORIAL ANNK UNION 31. Date filed (Month, Day, Year)

Registrar DHMH 17 Rev 1/2001

State

10

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month 9 2007 OctoBE2 Irma B. Kowaleski /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BACTIMORE WARHINGTON GUEN BURNIE ANNE MEDILAL CENTE If Under 1 Year Months Days 6. Sex If Under 24 Hrs 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 ☐ M 2 💢 F 86 056-14-7196 Director June 14, 1921 New York Usual Residence of Decedent should be filed within 72 hours after death with the Maryland of Mental Hyglene. marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10b. County 10d. Inside City Limits an "natural", or items 23a or 28a-f show Medical Examiner must be notified at Director New York Onondaga Syracuse 1 ☐Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 424 Tower Avenue 13206-1554 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: ģ 3 Widowed 4 Divorced White Completed . Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) the state Ball Bearing Factory Assembler 6 permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item Z7 Is marked othe any Injury or other traumosts. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lodovico Borgna Burelli ဥ Assunta 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Peter J. Kowaleski (Husband) <u>424 Tower Ave., Syracuse, New York</u> 13206-1554 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐Removal from State 4 □ Donation 5 □ Other (Specify) Bayview Crematory, Inc. 10/10/07 Baltimore, Maryland 21. Signature of Funeral Service Licensee Kevin E Ecker 22. Name and Address of Facility Mc Cully-Polyniak Funeral Home, 237 E. Patapson Ave. Balto shock, or heart failure. List only one cause on each line. 21225-1856 Balto., Approximate Interval Between Onset and Death Immediate Cause (Final Physician FHEUMONIA disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner death certificate be executed 68760,6 Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 □Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown 23d. Date of delivery 23b. Was decedent preofant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by The law requires 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No autopsy performe this certificate Division or Vital 1∐ Yes 2 NO 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day 27. Manner of Death 1 Natural funeral 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ Accident 2 □ No al or Attend after death | Director: filled in by the 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. d title of certi 29b. Signature 29d. Date signed (Month, Day, Year) 451249 address of person who comp ause of death (Item 23a) (Type, Print) ١٥

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month)

32/Registrar's Signature

P.O. Box 68760 Division or Vital Records,

> State Registrar

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

29c. License number

completed cause of death (Item 13a) (Type, Print)

and manner stated.

Hill CT Lutherville, MD 6 Trimble

Registrar's Signature OCT 1 0 2007

21221

YEARS

Year

Day

Month

29d. Date signed (Month, Day, Year)

9-24-2007

la or 28a-f show t be notified at "natural", or Items 23a edical Examiner must b permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any Injury or other traumatic event, the Medical E

**Physician** 

/Medical

Examiner

MD

Funeral

Completed

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Examine

Physician/Medical

Completed

Be

Certification: To

29a. Certifier (Check only one)

**Funeral** 

Director

Physician /Medical Examiner

To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A

Division or Vital Records, P.O.

10e. Street and Number 8545 Pulaski Highway 11 Marital Status 1 ☐ Never Married 2 ☐ Married 3 X Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11 th 17. Father's Name (First, Middle, Last) Dorsey Mock Myrtel Webber 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Nancy Weaver / daughter 4546 Austin Traphill Road Elkin NC 28621 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 I Burial 2 ☐ Cremation 3 ☐ Removal from State Holly Hill Cemetery 9/28/07 Baltimore MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 300 Mace Ave. Balto. MD Connelly Funeral Home of Essex 23a. Part1. Enter the disease, or complications that caused they eath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) HRONIC OBSTRUCTIVE PULMONARY DISEASE ue to (or as a consequence of) Sequentially list conditions, for y leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ robably 4 ☐ Unknown CHRONIC 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an performed 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Dother (Specify) HOSPICE 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 1/2001

State

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D0026327

OSS 6114 CAMFFIRE, COLUMBIA, MD 21045

DARWIN LAMAR KELLY JR Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2007 32345 UNK UNK Certificate of Death 1- For State Reg. No. Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day October 6, 2007 0220 hrs া Examiner Kelly Darwin Lamar b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Baltimore 1700 block of Homestead Street 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or If Under 24Hrs. If Under 1 Year 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** oreign Months Days Hours Min. Country) 2-2-1987 Director 217-13-1598 Md. 20  $_{1}X_{M}$ 2 F Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 1 XYes 2 No Baltimore NA 28a-f show other than "natural", or items 23a or 28a-f sho the M dical Examiner must be notified at once. Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 439 N. Linwood Ave. 21224 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Ongin? (Specify Yes or No-Funeral 12. Was Decedent Ever in U.S. 11. Marital Status thent of Health and Mental Hygiene.

timent of Health and Mental Hygiene.

riant: If item 27 is marked other than "natural", or item:
or other traumatic event, the Medical Examinar miset. Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Yes Specify: Black Divorced If Yes, Give Year Yes 2 X No specify: Widowed ۾ 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) Comple 10th grade 17. Father's Name (First, Middle, Last) Student 18.Mother's Name (First, Middle, Maiden Surname) Perry

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Be Darwin Lamar Kelly, Sr 19a. Informant's Name/Relationship (Type, Print ) Betty Kelly Grandmother 439 N. Linwood Ave., Baltimore, Md 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Baltimo
permit. Page
Department o
Important: 1 10-12-07 King Mem. Pk. Donation 5 Other Specify Randallstown, Md 22. Name and Address of Facility 21. Signature of Funeral Service Licensee March F.H. East 1101 E. North Ave., Baltimore, Md 21202 Approximate interval 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Between Onset and failure. List only one cause on each line. Death Viedical a. Shotgun Wounds Immediate Cause (Final disease \_xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause Examiner (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and tra sician/Medical AMENDED ling physician a as the burial -UNPENDED Box 68760, 23d, Date of delivery 23c. If yes, outcome of pregnancy Day Year 23b. Was decedent pregnant in the Month Live birth Fetal death 3 Ectopic pregnancy past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. o Yes 2 V No 3 Probably 4 Unknown ğ ۵ Completed Records, 24b. Were autopsy findings available 24a, Was an prior to completion of cause of autopsy performed? death? this certificate has 2 No 1 ✔ Yes 2 1 🗸 Yes 26.Place of Death (Check only one) or Attending Physician: 25. Was case referred to medical of Vital Be Other<sub>4</sub> examiner? Residence 6 V Other: Scene Hospital: 1 Inpatient 2 Nursing Home 5 DOA ER/Outpatient 3 1 Yes 28a. Date of Injury (Month, Day, Year) Oct 6, 2007 28d. Describe how injury occurred 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death After Subject was shot 0202 hrs Natural 1 Yes 2 ✔ No Pending Director: death. Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. Could not be or Town, State) 1700 block Homestead Street, Baltimore, MD Suicide (Specify) Local Street To the Funeral 4 V Homicide 29a. Certifier (Check only Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

₩ State

State 31. Date filed (Mo(1) Copy, 1ear)
Registrar

Ling Li, MD

2007 OCME

30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner

m. D

ORIGINAL

111 Penn Street, Baltimore, MD 21201

O.C.M.E.

October 6, 2007

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month 10 06 2007 8:45 AM M Wiley James Little 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore 7408 Sparr Drive 5. Social Security Number 6. Kingsville 8. Date of Birth (Month, Day, Year) 06/13/1941 Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday Days Hours 1 X M 2 □ F 66 North Carolina 220-36-4099 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 No Baltimore Kingsville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 21087 7408 Sparr Drive 14. Race - American Indian 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Błack, White, etc. 1 Yes 2 X If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married 2 X No 1 ☐ Yes 2 🔀 No Specify: 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DQ NQT use retired) Proficient 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+ Interior Painting Self-Employed 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Myrtle Jane Black Wiley Blaine Little 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 7408 Sparr Drive - Kingsville, Maryland (wife) Catherine A. Little 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State St. John Evang. Ch. Cemetery 10/10/2007 4 □ Donation 5 □ Other (Specify) Hydes, Maryland 22. Name and Address of Facility E. F. Lassahn Funeral Home, P.A. 21. Signature of Funeral Service Licenses 21087 11750 Belair Road - Kingsville, Maryland aa 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death CANCER Immediate Cause (Final TETASTA MOLITH disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for an a consequence off-Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Xes 2 No 3 Probably 4 Unknown 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 2 A No 26. Place of Death (Check only one) Other: 4 Nursing Home 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 ☐Other (Specify)

the burial-transit and Box 68760 attending physician pe use as P.O. ed by the a detached f signed by the Records, peen page 2 has Division or Vital director, funeral After

Examiner Physician/Medical þ Completed Be ဥ Certification: To the Hospital or Attendia within 24 hours after death.

To the Funeral Director: A completely filled in by the fu death.

**Physician** 

/Medical

Examiner

Director

Funeral

à

Completed

Be

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**Funeral** 

Director

item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at

d 2 should be filed within 7 in and Mental Hygiene. 7 Is marked other than "r

f Health tem 27

permit. Pages 1 an Department of Healt Important: If item 2 any Injury or other

**Physician** 

/Medical

Examiner

Maryland 21215-0036

3altimore.

25. Was case referred examiner? 27. Mann Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 atural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determine 4 Homicide

14 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29d. Date signed (Month, Day, Year)

31. Date filed (Month, Day, Year)

29a. Certifier

(Check only

0 20 Registrar's Signature

30. Name and pardress of person who completed cause of death (Item 23a) (Type, Print) G

State Registrar

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene, For State Registrar 32347 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Year ANG 7:24PM ELIZABETH 2007 OCTOBER /Medical 4a. Fecility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner BALTIMORE Baltimore City HOPKINS THE JOHNS HOSPITAL T ( If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 16, A32 Baltimore, Maryland 216 16 6854 25 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygleine. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examinal must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Baltimore City Baltimore tXXYes 2 □ No Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21213 2903 Edison Highway USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2XXNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes XX No Specify: Specify: White Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) N/A Waitress La Fountain Bleu 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Regler Thomas Bures Margaret 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Martin A. Lang (husband) 2903 Edison Highway Baltimore, Maryland 21213 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2XXCremation 3 ☐ Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc. October 9 2007 Baltimore, Maryland 21. Signature of Funeral Service Licensee once Lassann Funeral Home Inc. 390ha 7401 Belair Road Baltimore, Maryland 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Betw Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ARTERY DISEASE CORONARY /Medical Due to (or as a consequence of): **Examiner** HYPERTENSION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit The law requires that the death certificate be executed DIABETES and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, the attending physician Physician/Medical for use as the IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 ☐ Fetel dea 4 Pregnant at time of death 2 Fetel death 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 4 Zhinknown KIDNE 3 Probably 1 ☐ Yes 2 ☐ No page 2 should Completed peen s 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed: 2 🗆 No 1 Yes 2 100 1 Tes To the Hospital or Attending Physician: funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 1 ☐ Yes 2 Z No ဂ္ 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 3 DOA within 24 hours after death. To the Funeral Director: After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Matural 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 2 Accident filled in by the 6 Could not be determined 3 🔲 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number HD CCTOBER 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3100 CONNORS ROBERT WYMAN PARK DRIVE BALTIMORE 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 0 2007

DHMH 17 Rev 1/2001

State Registrar

31. Date filed (Month, Day, Year)

i cuteustein MI 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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ST, BALTIMORE MI

DHMH 17 Rev 1/2001

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend #3 Per State of Maryland / Department of Health and Mental Hygiene
Certificate of Death
Rea. No. 1 - For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** October 3, 2007 Ellen. Moore Crawford Lucy /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Holy Cross Rehab & Nursing Center Burtonsville Montgomery 8. Date of Birth (Month, Day, Yea Feb. 20, 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Year) 1915 Ohio 1 M 2 X Months Days Hours Min. 92 Director 279-38-0799 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural"; or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must he matter and once. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 XYes 2 No Director Montgomery Burtonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20866 IISA 3415 Greencastle Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No 2 Specify: Specify: White 3X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Social Services Social Worker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Anna P. Yent Stillman Crawford မှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Constance Jean Moore (Daughter) 96 Longview Lane Spotsylvania, VA 22553 20b. Place of Disposition (Name of cemetery, crematory or other place Medical Education Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) 10/5/07 Memphis, TN Research Institute 22. Name and Address of Facility
Mid South Mortuary 21. Signatur of Funeral Service Licensee 3788 Summer Avenue Memphis, TN 38122 Party Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician ougestive /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be axecuted Division or Vital Records, P.O. Box 68760, burial-trar and Due to (or as a consequence of): Physician/Medical the use as t IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗓 No Month Year 4☐Pregnant at time of death 9☐Unknown Day 5 Other (specify) signed by the a 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an rector, page 2 s autopsy autopsy performed? Yes 24 No Hospital or Attending Physician: director, 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one) Hospital: 2[XNo Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation ours after death. 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a

To the Funeral I

completely filled 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0054566 10/4/07. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

Bhogavilli.

31. Date filed (Month, Day, Year)

OCT 1 0 2007

li, 14 FCZ Chory heaf terrace Gilversyning, Mn 20906

De Registrar's Signature

	2		For State Registrar	State of Maryla		ificate of		иена пу		0 7	00051
3		-	Decedent's Name (First, Middle, Late	st)		mouto or	Bouin	2. Date of De		U /	3: Time or Death
	Physic /Medi		MALAC	CHI JAMES MIM	S			Month SEP	8 2007	Year	5:35 P M
	Exami		4a. Facility Name (If not institution, give				r Location of Death	1		y of Death	
	<u> </u>		NATIONAL NAVAL N			BET	HESDA  I If Under 24 Hrs.	T = = : : :=:		1ONTGC	
	Funeral Director		5. Social Security Number 6. S N/A	ex 7. Age (In y ☑X M 2 ☐ F		Months Days	Hours Min.	8. Date of Bi			lace (State or Foreign
100	ъ		Usual Residence of Decedent				23	Sep. 8	<u>, ZOO/</u>	Mar	cyland
	arylan show	_	10a. State 10b. County	10c.	City, Town or Loca	tion				10	0d. Inside City Limits
	he Ma 28a-f	ecto	VA Prince W	Villiam W	oodbridge						1 X Yes 2 No
	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at	by Funeral Director				10f. Zip Code			10g. Citizen of	What Coun	try?
	ms 23	Jera	3695 Wertz Drive	12. Was Decedent Ever in	n U.S. 13. Wa	22193 as Decedent of H	lispanic Origin? (Span, Mexican, Puert	pecify Yes or No	USA 14. Ra	ce - America	
9	after or ite	Ē	1 X Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 X No If Yes, Give	- 1	/es, specify Cub ☑Yes 2⊠XNo	an, Mexican, Puerti Specify:	o Rican, etc.)		ck, White, o	
003	ural";	d b	3 Widowed 4 Divorced	Year or Dates:					Speci		Lack
15-(	n 72 h "nati edica	lete	15. Decedent's Ed (Specify only highest gra	lucation de completed)	16a. Deceder	nt's Usual Occup nd of work done	eation during most of wor d)	king	16b. Kind of E	Business/Ind	lustry
212	l withi liene. r than	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	N,		-/		N/A		
DC :	e filed al Hyg other vent,	BeC	17. Father's Name (First, Middle, Last)				18. Mother's Nam	ne (First, Middle		me)	
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If leam 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	5	Anthony Mims				Tren	ita Hodg	ge		
Ja.	12 sho		19a. Informant's Name/Relationship (		19b. Mailing	Address (Street	and Number or Ru	ral Route Numb	per, City or Town	, State, Zip	Code)
e)	1 and Healti em 27 ther t		Anthony Mims /Fa 20a. Method of Disposition		3695 Vo. Place of Disposit		ive, Wood	dbridge Date	VA 22	2193	un Ctata
Baltimore,	ages ent of t: If it y or o		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specific	Removal from State	cemetery, crema	tory or other plac	i			•	
i i	mit. F vartme oortan injur		21. Signature of Funeral Service, Licer		Salem Cem	ecery Name and Addre	\$9/19 ss of Facility B		Humbole 11e Fun		
ä	Depar Impor any ir		Men St	endll			renue, Hu			343	
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	olications that caused the de	eath. Do not enter	the mode of dyir	ng, such as cardiac	or respiratory a	arrest,		Approximate Interval Between
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	cuted Id ransit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	C.							
, 0	e exerian ar urial-tı		resulting in death) Last	Due to (or as a cons	sequence of):						
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9 X			IF FEMALE:	23c. If yes, outcome pf pre-	палсу				001.5		
Вох	tnat the death cer ed by the attendir detached for use	Physician//	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐Live birth 2 ☐ F 4 ☐ Pregnant at time of	etal déath 3□E	ctopic pregnancy other <i>(specify)</i>	<u>′</u>		- 1	ate of delive onth	ry Day Year
Р,О	tt the d by the tached	hys	9 □ Unknown	9□Unknown							
Š,	irres tha signed d be de	by P	Part II. Other significant conditions of	ontributing to death but not i	resulting in the unde	erlying cause giv	en in Part I.	23e. Did	tobacco use con	tribute to th	e cause of death?
ord	w requir been si should I	ted						1 🗆	Yes 2X No	3 ☐ Proba	ably 4 □Unknown
Vital Records,	hasb je 2 sh	Completed						24a. Was auto	an 24b.	Were autor	psy findings available npletion of cause of
<u>a</u>	certificate ha								ormed? 2 ☐ No	death? 1 ☐ Yes	2 No
<u> </u>	ysician: is certific director,	o Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 [▼No	Hospital: 1 X Inpatient 2	☐ ER/Outpatient	all DOA Oth	26. Place of Dea				
0.	g rny er this eral d	n: To	27. Manner of Death	28a. Date of Injury	28b. Time of	28c. Injur Wor			idence 6 Otl		)
io	ath. or: After ne funer	atio	1 Natural 5 Pending 2 Accident investigation	I	) Injury		K? Yes 2 □ No				
	or Am ifter de Directo in by ti	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of injury - Al building, etc. (Spe	t home, farm, stree	t, factory, office		28f. Location ( City or To	Street and Num wn, State)	ber or Rural	Route Number,
	le Hospital of Attending 24 hours after death.  The Funeral Director: A pletely filled in by the form		29a. Certifier 1 X Certifying Ph	velolon. To the heat of a little	coulodes d-4	colleged at the cit	no dat 1 1				
	e nos 24 hc e Fun letely	Medical	(Check only one)	ysician: To the best of my k niner: On the basis of exam and manner stated.	ination and/or inve	stigation, in my o	ne, date and place pinion, death occu	, and due to the rred at the time,	cause(s) and m date and place	anner as sta , and due to	ated. the cause(s)
1	Io me nos within 24 ho To the Fur completely	Me	29b. Signature and title of certifier			29c. Licens	e number		29d. Date signe	ed (Month, L	Day, Year)
			- 2 inth	Zeil		010	1052964	(VA)	11 50	A 76	07

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NATIONAL NAVAL MEDICAL CENTER

0101052964 (VA)

11 Sep 2007

CHRISTOPHER H. REED CDR MC USN BETHESDA MD 20889-5600

31. Date filed (Month, Day, Year) OCT 1 0 2007 32. Registrar's Signature Gorle CALIFE.

Registrar

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / Department of Health and Men  State of Maryland / Department of Health and Men  Certificate of Death	tal Hygien	Z 11 11 1	32352
	Physici		1. Decedent's Name (First, Middle, Last)  John Eli Maree		oay Year	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Greenbelt	- 4	c. County of Deatl	
	Funeral Director		Months Days Hours Min.	Date of Birth Month, Day, Yea t 15 1		nplace (State or Foreign untry)
	Maryland f show	o	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location  Md Prince George's Greenbelt			10d. Inside City Limits 1⊠Yes 2□No
	with the P e or 28a- be notifi	Direct	10e. Street and Number 10f. Zip Code 20770		Citizen of What Co	untry?
36	d within 72 hours after death with the Maryland jiene. r then "naturel", or Items 23e or 28e-f show the Medical Examiner must be motified at	by Funeral Director	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  12. Never Married 2	Yes or No-	14. Race - Ame Black, White	
21215-0036	within 72 hour ene. then "naturel he Medical Ex	Completed t	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)		Kind of Business/	Industry
and 2	ould be filed voluted by Mental Hygie warked other i latic event.	Be	7th Painter  17. Father's Name (First, Middle, Last)	rst, Middle, Maid	en Surname)	
Maryland	sh and sand	To	19a. Informant's Name/Relationship (Type, Print)  Darlene Marie Williams  19b. Mailing Address (Street and Number or Rural Ro 5904 Cherrywood Terr	ute Number, City	y or Town, State, 2	
altimore, I			20a. Method of Disposition  1  Burial 2 Cremation 3 Removal from State  1  Other (Specify)  20b. Place of Disposition (Name of cemetery, crematory or other place)  Cheltenham Vet Cem 21 200	ber 20c.	Location - City or eltenha	Town, State
Baltir	permit. Page Department of Important: If any Injury or once.		21. Signature of Funeral Service Licensee  Chustle D Bluro Q 2019 MLK Jr Ave SE	ughlin	Funera	l Home
3	Pnysician		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or resshock, or heart failure. List only one cause on each line.  Immediate Cause (Final	spiratory arrest,		Approximate Interval Between Onset and Death
	/Medical Examiner		disease or condition resulting in death)  PANCREATIC CANCER  Due to (or as a consequence of):			
N.P.	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.			
8760,	cate be executed ohysician and the burial-transit		resulting in death) Last  Due to (or as a consequence of):  d.			
O. Box 68	The law requires that the death certificate be executed the lass been signed by the attending physician and oate 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown   23c. If yes, outcome of pregnancy   1   Live birth 2   Fetal death   3   Ectopic pregnancy   5   Other (specify)		23d. Date of del Month	ivery Day Year
rds, P.	quires that I n signed by uld be deta	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacc		the cause of death?
Records,	i: The law requir icate has been si r, page 2 should	Completed		24a. Was an autopsy performed: 1 Yes 2	prior to	atopsy findings available completion of cause of 2 No
Vital	Physicien: this certificanal director,	Be	25. Was case referred to medical examiner?  Hospital:			
of		n; To	27. Manner of Death 28a. Date of Floury Sept. 1 Sept. Injury at 28d. Injury at 28	5 A Residence Describe how in		cify) <sup>*</sup>
Division	ttending F death. ctor: After y the funer	catlo	2 Accident investigation M 1 Yes 2 No	Landin (Change	and Mombas as D	ural Route Number,
Divi	ital or Attenors after death	Certification;	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	City or Town, St	ate)	arar nodio ivanibor,
	To the Hospital or Attending within 24 hours after death.  To the Funerel Director: Attencompletely filled in by the fune	edical	29a. Certifier  (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred a and manner stated.	it the time, date	and place, and due	to the cause(s)
)	To the within 2 To the complet	W	29b. Signature and title of certifier Curfatusana ND 29c. License number  C. VERGARA - SOARES M. D. D1G619	29d.	Date signed (Mont ofamber)	h, Day, Year) 26, 2007
	Φ		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  C. VERGARA_SOARES 8200 PROFESSIONAL RACE, CANDO.	VER, M	0. 20185	
	Sta Regist		29b. Signature and title of certifier Curyanization MD 29c. License number  C. VERGARA - SOARES M. D. DICGIA  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  C. VERGARA - SOARES B200 PROFESSIONAL PLACE, CANDO.  31. Date filed (Month, Day, Year)  OCT 1 0 2007			

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		•	1 - For Stata Registrar	State of Maryla		artment of H <i>rtificate of L</i>		-	giene Rog. No.2	007	32353
	Physici	an	Decedent's Name (First, Middle, Last	0	11			2. Date of De. Month	Day	Year	3. Time of Death
}-	/Medic	al	4a. Facility Name (If not institution, give	HOWARD	MEM	JSHAW 4b. City. Town. or	Location of Death	OCTUBER		2007 ounty of Death	5:45 PM
	Examin	er	1 1	OSPITAL		BALTI			N/	'A	
	Funeral Director		5. Social Security Number 6. S		s. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bird (Month, Da Jan 15			lace (State or Foreign stry) y land
	and		Usual Residence of Decedent  10a. State 10b. County	10c. (	City, Town or Lo	ocation				1	0d. Inside City Limits
	Maryl	ţŏ	Maryland Anne A	rundel		Glen B	urnie				1 ☐ Yes 2X No
	or 28a	Directo	10e. Street and Number			10f. Zip Code			10g. Citize	n of What Coun	ntry?
	• 23a	stal	1044 Bell A		11.6 12	Mas Donadant of Hi	2106		14	USA Race - Americ	ean Indian
36	n 72 hours after death with the Maryland "natural", or iteme 23s or 28s-f show watest Extentiser has be notified at	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 ☑ Widowed 4 □ Divorced	12. Was Decedent Ever in Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: WW	2	Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2X No	spanic Origin? (S in, Mexican, Puert Specify:	pecny Yes or No o Rican, etc.)		Black, White,	
9500-6121	72 hou	ted	15. Decedent's Ed	lucation	16a Dece	dent's Usual Occupa	ation	vina	16b. Kind	of Business/Inc	dustry
1212	withi Bne. than	Completed	(Specify only highest graund (0.12) Unknown	College (1-4or 5+) Unknown		kind of work done of DO NOT use retired		kiiig	A & ]	P Tea C	0.
yland	be filed Ital Hygi of other	ВеС	17. Father's Name (First, Middle, Last)	Joseph Mews	haw		18. Mother's Nam		Maiden Su	ітате)	
<u> </u>	d 2 should th and Men 7 te marke treumatic	၉	19a. Informant's Name/Relationship (1	•		ng Address (Street a		a Clark	or City or T	Town State Zin	Codel
<u>8</u>	d 2 July a street of the stree		Lee Ulrich	(Nephew)		2 Stratto				21114	0000
Baitimore,	I TO THE	1 4	20a. Method of Disposition 1 ဩ Burial 2 ☐ Cremation 3 ☐		Place of Dispo	osition (Name of matory or other place	e)	Date	20c. Loca	tion - City or To	own, State
Ĕ	Pages tment of tant: if it tant: or o		4 ☐ Donation 5 ☐ Other (Specify	) C	-	11 Cemete		11/07	Balti	more, M	Maryland
Rai	permit. Page Department of Important: if eny injury or		21. Signature of Fureral Service Licen	see Kevin L. L	cker 2	2. Name and Addres McCully-P 237 E. Pa	ss of Facility olyniak tapsco A	Funeral ve., Bal	Home,	P.A. Md. 21	225-1856
			23a. Part1. Enter the disease, or companies shock, or heart failure. List only	olications that caused the de one cause on each line.							Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a ADVANCED		SMALL CE	u Lun	G CANE	ER		LYEAR
	Examiner			Due to (or as a conse	equence of):						
1	ם פ	iner	Sequentially list conditions, if any, leading to intriediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (or as a conse	equence of).						
20	and I-trans	Examin	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a conse	equence of):						
28/60,	ficate be executed physicien and is the burial-transit	edical E		d.	- 4						
		Medi	IF FEMALE:								
C. Box	e death certif the attending hed for use as	Physician/M	23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcome of preg 1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time of 9 ☐ Unknown	tal death 3[	□Ectopic pregnancy □ Other (specify)			230	d. Date of delive Month	ery Day Year
7.	res that the de signed by the a be detached f		Part II. Other significant conditions of	ontributing to death but not re	esulting in the u	inderlying cause give	en in Part I.	23e. Did t	obacco use	contribute to the	ne cause of death?
SD	w requires been sign should be	ed by	CHRONIC OBSTRUC	TIVE PLLMOS	JACY Di	SEASE		1 🔳	Yes 2 🗆 I	No 3□Prob	ably 4 Unknown
vital Records,	rsicion: The law requires that the certificale has been signed by th firector, page 2 should be detach	Completed						24a. Was autop perfo		prior to cor death?	psy findings available mpletion of cause of
Ia	en: Ti tificale tor. pa	0	25. Was case referred to medical				26 Place of Dea	1 ☐ Yes		1 🗌 Yes	2 No
٥ ۲	Physicien: r this certific ral director.	To B	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 Inpatient 2	☐ ER/Outpatie	nt 3 DOA Othe	20	lome 5 Resid		Other (Specifi	y)
	inding Physiclen: ath. ir: After this certific		27. Manner of Death  1 Natural 5 Pending 2 Accident investigation		28b. Time o Injury	Work	∕at ⟨? Yes 2 □No	28d. Describe I	now injury o	ecurred	
Division	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At building, etc. (Special Control of the C		reet, factory, office		28f. Location (. City or To		Number or Rura	il Route Number,
	e Hospit 24 hour e Funera	edical	29a Certifier (Check only one) 2 Medical Exam	yuiciam: To the best of my k niner: On the basis of exami and manner stated.	nowladge, deat nation and/or in	n occurred at the time exestigation, in my op	ne, date and plane pinion, death occu	, and due to the irred at the time,	causu(s) ar date and pl	to intumer as st lace, and due to	tated. o the cause(s)
	To the To the Comp	¥	29b. Signature and title of certifier	0 .	,	29c. License	number		29d. Date s	signed (Month,	Day, Year)
!	211		1000	Samuy, MD	INTERN		ES ØØ	Ø c	OCTOB	ER 7,	2007
	Px,		30. Name and address of person who	complete Cause of death (It	em 23a) (Type,	Print)	VEL S	BA BA	A 10 M 10	e Mn	21275
	Sta , Registr		31. Date filed (Month, Day, Year)  OCT 1 0 200	32 Registrar's Sig	nature	W.		1) 1		99 1 146	

DHMH 17 Rev 1/2001

David Leonard Moore

2007 32354

			For State		,	Certif	icate of	Death				Reg. No			<u> </u>	
DF	nysicia		egistrar . Decedent's Name (First, Midd	ile,Last)						2	. Date of D Month	eath Day	Yea	ar	3. Time of Deat	th
	iysicia Examin	<b></b>			M						October	5, 200	7		1458 hrs	
	-Autom	4	David Lec	on, give stre	et and number)		41	p. City, Town,	or Location of	of Death			c. County		1	
			101 East Avenue	- , 5				Hagersto	wn			'	Washin	gton		
				6. Sex	7 Δα	e (In yrs. last	hirthday)	If Under 1 Y	ear If Unde	r 24Hrs.	8. Date of	Birth (MN	/DD/YYYY		thplace (State or	
	neral	-	Social Security Number			e (iii yis. iast	Dillinady)		ays Hours		1			Foreig	ountryCA	- 1
Dir	ector	- 16	523-20-5546	1X M	2 F	23	Yrs.				12-1	0-8	3		MATCA	
		Ī	Jsual Residence of Decedent												10d. Inside Cit	v Limits
	g g	Γ	10a. State 10b. County	•		10c. City, To	wn or Location	on							1 Yes 2	
Ф	how		MD Was	hingt	on	Hage	ersto	พท								MILE
rylan	a-fs	왕는	10e. Street and Number	111119	-011	1,209		10f. Zip Cod	е			10g. Ci	tizen of W	hat Cou	intry?	
Ma	23a or 28a-f show any notified at once,	Director	105 East W	achir	arton	C+ 7	n+ 21.7						USA			
th th	23a c				. Was Deceden		13 Was	Decedent of	Hispanic Original	gin? (Spe	cify Yes or	No-			rican Indian, Blac	ck,
h wi	items 23a ust be noti	Jer.	11. Marital Status  1 XNever Married 2 1		Armed Forces	?	If Ye	es, specify Cu	ban, Mexican	, Puerto F	Rican, etc.)		Whi	te, etc. Z	frican	
deat	or it	Funeral	71	1	Yes 2	X_ No		Yes 2X	No specific				Specify:		rican	·
after	'al",	<u>_</u>		ivorced If Ye	Dates:			t's Usual Occ			ork done	16b	, Kind of B	usiness	/Industry	
ours	atur E	교	15. Decedent's Education (Sp				during mo	ost of working	life. DO NOT	use retire	ed)					1
72 h	* E E	Completed	Elementary/Secondary (0-12	2)	College (1-4 or	5+)	_	,					Food	lser	vice	
03 ithin	r th	티			1		Lа	<u>borer</u>	40 Motho	de Name	(First, Midd	lo Maide	n Surnam	e)		
6d ×	Tygic othe	ပို	17. Father's Name (First, Midd	e, Last)												ŀ
21215-0036 Muld be filed within 72 hours after death with the Maryland	Mental Hygiene. marked other than "natural", c event, the Medical Examiner	a	James Lee 19a. Informant's Name/Relation	Moore	e			Address (S	Der	si I	2hil	ips	City or To	um Stat	to Zin Code)	
<b>24</b>	e a de	2	19a. Informant's Name/Relation	nship (Type,	Print )									CITAT '	201 20	ļ
MD d 2 shc	27 is		James L. Mo	ore/	Father		3030	Oakle	igh L	ane,	<del>_ 43</del>	man L	OMIT	1000	381 38 or Town, State	8
and and	nt of Health and It: If item 27 is rother traumatic		20a. Method of Disposition			1 00	ace of Dispos ematory or otl	ition (Name o	f cemetery,							
more Pages 1	t of I	- 1	1 X Burial 2 Cremati	on 3 I	Removal from S	olate	w Par			10/	17/0	7 M	emph	is,	TN	
E a	tant	1	4 Donation 5 Other			Ive	N Pal	Jame and Add	tress of Facili	tv						
Baltimore, permit. Pages 1 a	Department of Health an Important: If item 27 injury or other traums		21. Signature of Funeral S rvi				1,5			'Har	i P.	CT	ose	F.	Svs,P.	A,
ша	.A = .E		23a. Part I. Enter the disease,	7-	Le_	al the death. I	151	26 Be	lair	cardie or	Ralt r respirator	y arrust, s	MD 2 shock, or h	neart	Approximate	e Interval
	sician		23a. Part I. En or the disease, failure. List only one cau	se on each i	ine.			no mode or a	, mg, cach as	-13:		1180			Between O	
	adical.	- 1	Immediate Cause (Final disea		ınshot Woul	nd to Head	<u> </u>								-	- 4
_Xa	ıminer		or condition resulting in death	) Due	e to (or as a con	sequence of)	•									
			Sequentially list conditions,	b												
		ē	if any, leading to immediate cause. Enter Underlying Cau		e to (or as a cor	nsequence of)	:									
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, ,	physician athe burial -	Medical	UNPENDED										23d. Date	of deliv	/erv	
760,	phys	/Me	IF FEMALE: 23b. Was decedent pregnant i		23c. If yes, outo		ancy	etal death	3 Ecto	nic pregna	ancv		Month		-	Year
<b>68</b>	tending use as	an	past 12 months?	ŀ	1 Live birth	at time of dea				p.op.og.		İ				
Box 68	the attending ed for use as 1	sician/	1 Yes 2 No 9	Unicanus	9 Unknown		9 🗌 0	ther (Specify				-				
2	the att	Phy	Part II. Other significant cor				sulting in the	underlying ca	use given in	Part I.	23e.	Did toba	cco use co	ntribute	to the cause of	death?
P.O.	ed by Jetach	by F	Part II. Other significant con	101110110	Jilli Daling to ac			, ,			1	Yes	2 🗸 No	3F	Probably 4 🔲 l	Jnknown
<b>1</b>	signed be deta	pe	<u> </u>								24a	Was an	1 24	b. Were	autopsy finding	s available
Ę į	s been sign should be	Completed										autopsy		prior death	to completion of	cause of
္မ	e has	ш									1	performe Yes 2		1 🗸		No
of Vital Records,	certificate ector, page	ပိ	of W	diant				26	Place of Dea	th (Check	only one)					
豆	certi	Be	25. Was case referred to med examiner?		spital:	atient 2	ER/Outpatier		Other		ng Home	5 Re	sidence	6 <b>V</b> O	ther: Scene	
> 1	this aldir	ျ	1 ✓ Yes 2 No		Пре		28b. Time of		c. Injury at W		_		v injury oc	curred		
j o	ng r After unera		27. Manner of Death		28a. Date of (Month, Da FOUND:	injury ay,Year)	FOUND:	1 1	1 Yes 2		Subjec		1 7			
e i	eath.	[ 읉		Pending nvestigation	Oct 5, 200	7	1453 hrs						No. of Miles		r Rural Route Nu	mbor City
Division	r Ar ter de irect n by	<u>ដ</u> ្ឋ		Could not be	28e Place o	of Injury - At ho	ome, farm, str	eet, factory, o	ffice building	, etc.	28f. Loca or T	ation (Stre own, Stat	eet and Nu	imber or	Rurai Roule Nu	illiber, City
وَّ	Spiral or Attending Engsician: The hours after death.  neral Director: After this certificate y filled in by the funeral director, page	Certification:		determined		Multi-Fami	iy Apt				101 Eas	t Avenu	e, Hager	stown,	MD	
	To the Hospita or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certificompletely filled in by the funeral director,		20a Certifier	g Physician	n: To the best o	f my knowled	ge, death occ	urred at the ti	me, date and	place, an	d due to th	e cause(	s) and mar	nner as	stated.	
3	To the Host within 24 hd To the Fun completely	Medical	(Check only one) 2 Medical	Examiner: C	on the basis of e	examination a	nd/or investig	ation, in my o	pinion, death	occurred	at the time	, date an	d place, a	nd due t	to the cause(s)	
	Vithin To the comple	led	29b. Signature and title of ce	ä	ind manner stat	ed			License numb						(Month, Day, Yea	ar)
		2	23D. Signature and file of Ce	7	11 8	*			O.C.M.E.				October	6, 20	07	
			Marie 15	rash	14 111											
	À	1	30. Name and address of pe	rson who co	mpleted cause	of death (Item	1 23a)		- D-10	Dre ME	24204					
	7		Melissa Brassell, N	ID Ass	sistant Medi	cal Examii	ner 111	Penn Stre	et, Baltım	Dre, IVIL	ا 2120 کے ر					
		itate	31. Date filed (Mann, Pay Y	eav ann	32 Regi	strar's Signat	ile	de								
			4 111.1	U 2007	fall self	is so	600									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Physician Month Myers Walter /Medical Facility Name (If not institution, give street and number) City, Town, or Location of Death 4c. County of Death Examiner Md. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours 1 XM 2 ☐ F 246-40-0761 N.C. Director 76 3-23-1931 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County ms 23a or 28a-f show must be notified at 1♥Yes 2 No Director Baltimore Md. 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21239 USA 1801 Wadsworth Way Funeral permit. Pages 1 and 2 should be filed within 72 hours after dea Department of Health and Mental Hygiene.

By in a filem 27 is marked other than "natural", or Items; any injury or other traumatic event, the Medical Examiner muonee. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: Black Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Mill Wright Bethleham Steel 9th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Myers, Sr. Walter Lille Bell Hooper ၉ Maryl 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21206 1801 Wadsworth Way, Baltimore, Md. Cynthia Myers Wife timore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 \ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 10-16-07 Randallstown, Md. King Mem. Pk. 22. Name and Address of Facility 21. Signature of Funeral Service Licensee March F.H. East 21202 1101 E. North Ave., Baltimore, Md. lade ware 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Approximate Interval Between Onset and Death MINULES Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner physician and the burial-transit Physician/Medical IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy for in the past 12 menths? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f o 9∏Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 2 No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed ves 2 1□ Yes Vital Physician: 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 □ DOA this o funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Hospital or Attending 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident hours after death. within 24 hours after death To the Funeral Director: completely filled in by the 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the pasis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signa D0042083 10-08-2007 cause of death (Item 23a) (Type, Print) rson who complete Blud, Baltimore MD 21239

Registrar
DHMH 17 Rev 1/2001

gistrar's Signature

2007

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day INEZ MILLER Physician 2007 October 8 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Co. Glen Burnie Baltimore-Washington Rehab Center If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) June 22, 19 5. Social Security Number Age (In yrs. last birthday, Birthplace (State or Foreign Country) **Funeral** 1□M 20 F 1923 Director 216-16-9877 84 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at Md. Anne Arundel Co. Linthicum 1 Yes 2 No Director 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 312 Cheddington Rd. 21090 U.S.A. permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a any injury or other traumatic event, the Medical Examiner must once. **Funeral** 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: White <u>م</u> 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) General Electric Service Rep. Lamp Division 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Seward Virginius F. Riley Tnez ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Charles Miller, husband 312 Cheddington Rd. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 10/9/07 Baltimore, Md. 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gonce Funeral Service P.A. 4001 Ritchie Hgwy. Baltimore, Md. 21225 ramerou 23a. Part1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Metastatic 2 Ceterin Caucer **Physician** reast Serevelwastig /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1☐ Yes 2☐ No Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2□No 1∐ Yes 1 TYes Be ( 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 1 Natural 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours aft To the Funeral Di completely filled in 1XG Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier and olived

State Registrar

31. Date filed (Month, Day, Year)

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DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GLEN AURME, Md. 21061

32 Registrar's Signature

0029873

29d. Date signed (Month, Day, Year)

10/09/07

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Myrtle Elizabeth Mehring 11:00 PM October 8, 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Gilchrist Center for Hospice Care Towson Baltimore Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 ☐ M 2 🔀 F 215-36-8132 Director MD Feb. Usual Residence of Decedent with the Maryland 10c. City, Town or Location r 28a-f show notified at 10a. State 10b. County 10d. Inside City Limits Director MD Baltimore Upperco 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? d other than "natural", or items 23a or event, the Medical Examiner must be 21155 5025 Old Quarter Road Funeral U.S.A. permit. Pages 1 and 2 should be filed within 72 hours after death \\ Department of Health and Mental Hygiene. \\ Important: If Item 27 is marked other than "natural", or items 23s any injury or other traumatic event, the Medical Examiner must 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2K No White Specify: Completed by 3 X Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Luther W. Moser Helen K. Batz 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) George Mehring 5025 Old Quarter Road, Upperco, MD 21155 Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State All Saints Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 10-13-07 Reisterstown, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 11824 Reisterstown Road ELINE FUNERAL HOME Reisterstown, MD 21136 23a. Part1. Enter the diseas shock, or heart failure. disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Schemic **Physician** 1000s /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Que to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-transit Division or Vital Records, P.O. Box 68760-Due to (or as a consequence of): Physician/Medical attending ph I for use as the IF FEMALE ed by the attendin detached for use . If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Day Month Year 4□Pregnant at time of death 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an has autopsy certificate ha 1□ Yes 2 XX 25. Was case referred to medical funeral director Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Mother (Specify) NOSO(CO Certification: To 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3□ DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 ☐ Pending investigation (Month, Day Year) 1 Natural Injury 1 □ Yes 2 □ No after death. I Director: / 2 Accident 6 Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours aff To the Funeral D completely filled in 🖅 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

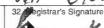
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State Registrar

CHAMIS 31. Date filed (Month, Day, Year) OCT 1 0 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier



29d. Date signed (Month, Day, Year)

lucles ST TONDON NO ZILOY

John Louis Marx

07-07690 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day October 1, 2007 1904 hrs Medical Examiner John Louis Marx 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 624 Rappolla Street Baltimore 5. Social Security Number 6. Sex If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) Funeral Days Min. Months Hours Director Country) MD 02.21.1938 213. 34. 091 Usual Residence of Decedent 10d. Inside City Limits nny 10b. County 10c. City, Town or Location is 23a or 28a-f show e notified at once, 1 Yes 2 No 28a-f show MD N/A Baltimore permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Inportant: I item 27 is marked other than "natural", or items 310 me. Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code U.S.A. 624 Rappolla Street 21224 Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Yes Specify: White If Yes, Give Year Widowed Divorced 1 Yes 2 No specify 2 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 6b. Kind of Business/Industry leted during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) item 27 is marked other than "traumatic event, the Medical Baltimore, MD 21215-0036 Compl Truck Driver Baltimore City 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary Reichart George Marx 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21213 19a. Informant's Name/Relationship (Type, Print) Beverly Marx/sister in 1aw 8348 Old Philadelphia Rd. White Marsh, MD 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 20a. Method of Disposition crematory or other place) or other Burial 2 Cremation 3 Removal from State 10.07.07 Beltsville, Chesapeake Crem. Donation 5 Other Specify: 22. Name and Address of Facility Cremation And Funeral Balto 21/Signature of Funeral Service Licensee Alternatives 8717 Green Pastures Dr. 23a. Par N. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line. /Medical Death a. Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease kaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): Examiner if any, leading to immediate (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and - transit To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death, Physician/Medical s been signed by the attending physician should be detached for use as the burial -UNPENDED AMENDED Records, P.O. Box 68760, 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Month Live birth Day Year Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 V Unknown Diabetes Mellitus Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of After this certificate has funeral director, page 2 st death? performed' Yes 2 V No To the Funeral Director: After this certificompletely filled in by the funeral director, 26.Place of Death (Check only one) 25. Was case referred to medical Division of Vital Be examiner? Inpatient 2 ER/Outpatient 3 Nursing Home 5 \_\_\_ Residence 6 ✔ Other: Scene 1 V Yes 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death Certification: 1 V Natural Yes 2 No 5 Pending 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be or Town, State) Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. October 2, 2007 30. Name and address of person who completed cause of death (Item 23a) n Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Ana Rubio MD. 31. Date filed (Month, Day, Year)

ORIGINAL

State Registrar

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** 12 NICHOLS LILLIAN 2007 07 OctoBER /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMORS CENTER RANDALS TOWN HOSPITAL NORTHWIEST If Under 1 Year If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Months Hours Min. 1 ☐ M 2 🛛 F 94 213-12-0614 Director Feb. 21, 1913 Maryland Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits show "natural", or items 23a or 28a-f shov edical Examiner must be notified at 1 ☐ Yes 2 No Director Baltimore Reisterstown 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code within 72 hours after death with 5 Campitelli Court 21136 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ② No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify þ 3 XWidowed 4 □ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry other traumatic event, the Medical (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any injury or other traumatic event, the Me College (1-4or 5+) 0wner Restaurant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Charles Roby 2 Estelle Evans 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Campitelli Court, Reisterstown, MD 21136 Dale N. Bernarding Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Druid Ridge Cemetery | 10/11/07 Pikesville, MD 21. Signatur f Funeral Service Licensee 22. Name and Address of Facility 11824 Reisterstown Road The Eline Funeral Home Reisterstown, MD 21136 Approximate Interval Between Onset and Death Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immr diate Cause (Final disc ase or condition sulting in death) RESPIRATORY Physician DISTIZESS ACUTE /Medical Due to (or as a consequence of): **Examiner** EPSIS Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last to (or as a consequence of) Examine certificate be executed NEUMONIA burial-transit and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 attending physician Physician/Medical as the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death asn 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? ō Month Day 5 Other (specify) the 9 ☐ Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ TYPERTENSION 1 Yes 2 No 3 Probably 4 Unknown Completed DYSLIPIDEMIA 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe certificate 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 10 1 Impatient 1 ☐ Yes 2 ER/Outpatient 3□ DOA ဂ this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3∏ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

To the Hospital or Attending P within 24 hours after death. To the Funeral Director: After it completely filled in by the

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DHMH 17 Rev 1/2001

State Registrar

Medical

31. Date filed (Month, Day, Year) OCT 1 0 2007

CROSSIZOADS

29b. Signature and title of certi

(Check only one)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR

OWINGS MILLS 210

29c. License number

D42827

29d. Date signed (Month, Day, Year)

21117

MD

OCTOBER 67, 2007

Baltimore Birthplace (State or Foreign Country)
\_\_\_\_\_\_ Maryland 10d, Inside City Limits 1 ☐ Yes 2 No 10g, Citizen of What Country? 14. Race - American Indian, Black White etc. Specify: White 16b. Kind of Business/Industry Northrop Grumman 20c. Location - City or Town, State Baltimore MD 300 Mace Ave. Balto. MD 21221 Approximate interval Between Onset and Death MONTH 23d. Date of delivery Month Dav Year 23e. Did tobacco use contribute to the cause of death? 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Residence 6 Other (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 29d. Date signed (Month, Day, Year)

3:15

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)
OCT 1 0 2

32. Registrar's Signature

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** ce OCTOBER 6,2007 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner DAMACITAN rood Age in yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Months Hours Days -38-86 1 M 2 □ F Yrs Director APRIL 9,1935 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10b. County Od. Inside City Limits 28a-f show Examiner must be notified at 1 Yes 2 No min Director BAITIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 2011 Wis 23a Funeral 14. Race - American Indian, Black, White, etc. 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1974es 2 No 1958 If Yes, Give Year or Dates: ARM 1 Never Married 2 Married Baltimore, Maryland 21215-0036 'natural", or 1 ☐ Yes 2 No B/ACK þ Specify: 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) the Medical 16b. Kind of Business/Industry other than Elementary/Secondary (0-12) College (1-4or 5+) BAITO, CITY SANTATION NO Worker 17 Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important; If Item 27 Is marked oth any lipluy or other traumatic event once. Be 19a. Informant's Name/Relationship (Type. Print) ral Route Number, City or Town, State, Zip Code) 19b. Mailing Address (Street and Number or Ru RAndelistown MD Oliver 3 Allenswood 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Fungral, Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician DEHYDRATION TPUTENSION /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of: Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed physician and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. Physician/Medical the attending pl IF FEMALE: 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy 1 Live birth 2 Fetal death in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown 24a. Was an autopsy performed} 1□ Yes 2 ☑ No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has certificate ha 25. Was case referred to medical examiner?

1 Yes 2 No funeral director 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending investigation Injury s after dea. 1 ☐ Yes 2 ☐ No 6 ☐ Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide within 24 hours af

To the Funeral D

completely filled i 🖊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 30., Name and address of person who completed cause of death (Item 23a) (Type, Print) -ACATHIC SHASHID 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

OCT 1 0 2007

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 7:15 ITTS 2007 PM MICHAEL 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death NA Johns topkine 105 pita Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Hours 1 XM 2 □ F 53 146-52-5689 7-5-1954 N.C. Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 □Yes 2 No Bowie Prince Georgest Md. 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20721 USA 10323 Tuliptree Dr. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No 1 ☐ Yes 2 ☑ No Specify: Black 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Telecom 12th grade Manager 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pitts Leon Catherine Holding 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 10323 Tuliptree Dr., Bowie, Wife Karen Wilson Pitts 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Newligh Church Cem. 10-9-07 Wake, N.C. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F.H. East nando- Milan 1101 E. North Ave., Baltimore, Md. 21202 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) VARICEAL U days ISOPHAGEAL Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Due to (or as a consequence of). F FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 3b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 9□Unknown 5 ☐ Other (specify) nditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Tyes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 Yes 2 No edical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 3□ DOA 28d. Describe how injury occurred

**Physician** /Medical Examiner

**Physician** 

/Medical

**Funeral Director** 

q

Be Completed

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Examiner

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any lujury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Examiner physician a To the Hospital or Attendir within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

the Hospital or Attending Physician: The law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760,

Medical Certific

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9 ∐ Unknown
Part II. Other significant co
25. Was case referred to me examiner? 1 ☐ Yes 2 ☑ No
27. Manner of Death 1 Natural 5 □P

2 Accident

3 ☐ Suicide

29a Certifier

4 Homicide

)	"
5  □Pending investigatio	n
6 ☐ Could not b	е

☐Pending investigation	
Could not be	

łc	ospital: 1 propatient 2	ER/Outpatient	,
	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	

28c. Injury at Work? Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s)

29b. Signature and title of certifier	
1 100	A A

29c. License number REJ-000

29d. Date signed (Month, Day, Year)

ss of person who completed cause of death (Item 23a) (Type, Print)

600 A. WOLFE ST. ABBUL NOUR, BALTIMORE, MD, 21205 JOHNS HOPICUS HOSPITAL

State Registrar

and manner stated



		For State	State of M	laryland /	-	ment of He		_		, ,,,,,,	
		Registrar     Decedent's Name (First, Middle, La	st)		Oertin	cate of L	,cair	2. Date of De		3. Time of Death	
Physici /Medio		Mary		kowski	· ·			Octobe	1 2007	9:30 A <sup>M</sup>	
Examin	ner	4a. Facility Name (If not institution, giv		)	4b		Location of Deat	h	4c. County of De	gomery	
Funeral		Holy Cross Host  5. Social Security Number 6. S	Sex 7 A	ge (In yrs. last b		Under 1 Year	Spring If Under 24 Hrs	8. Date of Bir	th 9.B	irthplace (State or Foreign	
Director		379-30-2313	і□м Ж.ғ	76	Yrs. Mo	onths Days	Hours Min.	Oct. I	7. 1020 L	known)	
land ow It		Usual Residence of Decedent  10a. State 10b. County		10c. City, Tov	wn or Locatio	on				10d. Inside City Limits	
a-f sh	ctor	Maryland Montgon	nery			Silver	Spring			1 ☐ Yes 2 📉 No	
vith the	Director	10e. Street and Number.			1	0f. Zip Code	901		10g. Citizen of What C	•	
ns 23a must	Funeral	100 Plymouth St.	12. Was Decedent	t Ever in U.S.	13. Was			Specify Yes or No to Rican, etc.)		nerican Indian,	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.	þ	1 □ Never Married 2 □ Married 3 🏧 Widowed 4 □ Divorced	Armed Forces 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:	No		s, specify Cubar Yes 2⊠ No	n', Mexican', Puèr Specify:	to Rićan, etc.)		nite, etc. White	
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2 shou and N is mar aumat	-	19a. Informant's Name/Relationship (	Type. Print)		-				per, City or Town, State		
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20 E # 9			naun		933	Gist A	ve. Si	lver Spr	ing, MD	20910 Approximate	
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ath, ath, or: Afte	atior	1 X Natural 5 ☐ Pending 2 ☐ Accident investigation		ay Year)	Injury 1		? ∕es 2∐No				
or Atte	Certification:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	28e. Place of in	njury - At home, f etc. (Specify)	farm, street,	factory, office			Street and Number or wn, State)	Rural Route Number,	
To the Hospital or Attending Physician: within 42 hours after death, To the Funeral Director After this certifica completely filled in by the funeral director, it	edical Ce			of examination a					cause(s) and manner , date and place, and d		
To the within To the comp	Me	29b. Signature and title of certifier	2 10	7.		29c. License			29d. Date signed (Mo		
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H		30. Name and address of person who Ghousia Sultana					ccle, Si	lver Spi	ring, MD 2	20906	
Sta		31. Date filed (Month, Day, Year)	32. Regist	trar's Signature					<del>-</del> -		
Registr	rar	OCT 1 0 2	007 Alen	we to	Apo	de la					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death RICHARDS. **Physician** BABETTE B. 11:45Am 2007 OCTOBER /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner BALTIMORE. RANDALLS TOWN. HOSPITAL CENTER NORTHWEST | Months | Days | Hours | Min. | 8. Date of Birth | Months | Days | Hours | Min. | 03/13/1913 cial Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex Funeral 1 □ M 2 ₩ F 545-16-0633 94 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits at iral", or items 23a or 28a-f sh Examiner must be notified 1 ☐ Yes 2 V☐ No Director MD HOWARD ELLICOTT CITY 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21042 U.S.A. 4348 WILD FILLY COURT Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mential Hygiene. Important: If Item 27 Is marked other than "natural", or iter any Injury or other traumatic event, the Medical Examiner. 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No WHITE altimore, Maryland 21215-0036 Specify 3 Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) TRAVEL AGENT TRAVEL 4 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be BEAR BELLE SCHWAN ARTHUR ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 4348 WILD FILLY COURT - ELLICOTT CITY, MD 21042 SUZANNE POSNER / DAUGHTER 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 X Removal from State 4 ☐ Donation 5 ☐ Other (Specify) FOREST LAWN 10/10/2007 NORFOLK, VA. 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licensee. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardlac or respiratory arrest, shock, or heart failure. List only one cause on each line. CEREBROVASCULAR Immediate Cause (Final **Physician** ACUTE disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leaving to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 5 ☐ Other (specify) signed by the a 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by SEPTICEMIA 1 Yes 2 No 3 Probably 4 Unknown DSTEOMYELITIS 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy performed? Yes 2 No or Attending Physician: funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 2 Accident Injury 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: completely filled in by the f 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide the Hospital CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and certifier HYSICIAN OCTOBER 07

State Registrar

U

31. Date filed (Month, Day, Year) OCT 1 0 2007

ERAHALL

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5401 AVVERAHALLI HARISH NORTHWES 32/Registrar's Signature

NORTHWEST WOSPITAL CEMER

RAMDALLSTOWN

OLD COUNT ROAD

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Phy	sicia	an	1. Decedent's Name (First, Middle,	Last)	K	050	211			2. Date of D	Da	ay 5 2007		of Death
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			Northwest	Hospital					llston			Balt		
Fune Direc	_		5. Social Security Number 216–12–9517	i. Sex 7. Ag 1  M 2  F	ge (In yrs. i	last birthday Yrs.	Months		f Under 24 Hrs. Hours Min.	8. Date of Bi	ay, Year	Co	intry)	e or Foreign
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arylan show	ğ	7	10a. State 10b. County		10c. City	y, Town or L	ocation.						10d. Inside	City Limits es 2 ☑ No
the M 28a-f		Director	MD BALT	IMORE	L	BALTI	MORE 10f. Zip	Code			10a C	itizen of What Co		<del>X</del>
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permit. Departr	once		) El	711	X		8900	REIST				N & BRUS KESVILLE		
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Physici /Medic			Immediate Cause (Final disease or condition resulting in death)	a. Chronic Due to (or as	hyp	er ca	pnic	resp	piratory	, fail	ure	_	Yea	
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rtificate	88	Medi	IF FEMALE.	U										
ath ce	asn io	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1☐Live birth	2 □ Feta	I death 3	□Ectopic pr					23d. Date of del	very Day	Year
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To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Puneral Director: After this certificate has been signed by the attending physicial promoted within the funeral director man 2 should be detached for use as the buring			29a. Certifier 1 Certifying (Check only 2 Medical E	Physician: To the best xaminer: On the basis	of my kno	wledge, dea	ath occurred	at the time	, date and place	e, and due to th	e cause(	(s) and manner as	stated.	20(6)
the H hin 24 the Fi		Medical	one)	and manner s	tated.	ulon and/or				arred at the time				
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			30 Name and address of person w	ho completed cause of	death (Item	- 23a) (Type	e, Print)			1	//	tober o		
	(P		DRoggen	5400 01	d Co	urt	Road	Sui	te 108	Kando	alls i	10wn N	1) 2	1133
Reg	Sta gistr		31. Date filed (Month, Day, Year)  OCT 1 0 20	32. Regist	rar's Signa	ture	de la							

07-07709 Colleen Russell Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Olleen Russell		For State	Certificate o		a monta ing	Reg. I	20	07 3236	
Physician	/ 1	egistrar Decedent's Name (First, Middle, Last)	, (	) ,		Date of Death  Month Da	y Year	3. Time of Death 1900 hrs	
ledical Examine		ia. Facility Name (if not institution, give street and number)	h K	4b City Town or	Location of Death	October 2, 20	307 4c. County of Dea		
		Franklin Square Hospital		Rosedale			Baltimore Co		
Funeral Director	2/2-88-4003 1 M 2 XF 45 Yrs. Months Days Hours Mill. June 25,1962								
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Aaryland 28a-f show any 1 at once.	ا ة	m.D. NA	BATT	more				1 Yes 2 No	
Maryl.	Director	0e. Street and Number		10f. Zip Code		10g.	Citizen of What Co		
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lospita 4 hours nunera		4 Homicide  29a. Certifier 1 Certifying Physician: To the best of my	knowledge, death oc	curred at the time,	date and place, and	due to the cause	(s) and manner as	stated.	
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E 3 E 8	ğ	29b. Signature and title of certifier			nse number		29d. Date signed October 3, 20		
	Į	anest	-th (th 00)	0.0	C.M.E.		October 3, 20	-	
0		30. Name and address of person who completed cause of dea Ana Rubio MD. Assistant Medical Exami	atn (Item 23a) ner 111 Penr	n Street, Baltir	nore, MD 21201				
St	ate	31. Date filed (Month, Day, Year) 32 Registrar's		and a					
Regist		DET: 1 0 2007. Elegan	D AS						

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2	Physici	an	Decedent's Name (First, Middle, Last)				2. Date of Death Month	Day Year	3. Time of Death
	/Media	al	Mary F. Stevens				Septembe	r 30, 2007	1:25 P M
	Examir	er	4a. Facility Name (If not institution, give street and numb Prince George's Hospital	er)	4b. City, Town, or Loca Cheverly	ition of Death		4c. County of Death Prince (	
	- Funeral		5. Social Security Number 6. Sex 7.	Age (In yrs. last birthday)	If Under 1 Year   If U	nder 24 Hrs.	8. Date of Birth	9. Birth	place (State or Foreign
	Director	5	249-52-8344 <sup>1□ M 2</sup> EF	73 Yrs.	Months Days Ho	urs Min.	July 3,	1934 Sout	th Carolina
	and and		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Lo	cation				10d. Inside City Limits
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	or 28.	Sirec	10e. Street and Number		10f. Zip Code		10	g. Citizen of What Cou	intry?
	ath w	ral	9715 Summit Circle #1B		20774			U.S.A.	
	iter de	Funeral Directo	11. Marital Status 12. Was Decede Armed Force 1 Never Married 2 Married 1 Yes 2	ent Ever in U.S. 13. V es? XINo	Was Decedent of Hispani f Yes, specify Cuban, Me	ic Origin? (Spe exican, Puerto F	cify Yes or No- Rican, etc.)	14. Race - Amer Black, White	
5	ours a	by	3 ☑ Widowed 4 □ Divorced If Yes, Give Year or Date		1□Yes 2XNo <i>Spe</i>	ecify:		Specify: Blac	ck
7	72 h	etec	15. Decedent's Education (Specify only highest grade completed)	16a. Deced (Give	dent's Usual Occupation kind of work done during DO NOT use retired)	most of working	1	6b. Kind of Business/li	ndustry
2	ified within 72 hours after death with the Maryland typiene. other than "natural", or items 23a or 28a-f show ont, the Modical Examinational by utilitied at	Completed	Elementary/Secondary (0-12) College (1-4	Or 5+1	lomemaker			Own Home	
מ	be filed tal Hygi d other event,	Be Co	17. Father's Name (First, Middle, Last)			Mother's Name	(First, Middle, M	aiden Sumame)	
yar	ould by Menta Menta arked	To E	Henry M. Scarborough			Lula Ma	y Bowman	n	
Maryjand 21215-0036	jes 1 and 2 should be flie of Health and Mental Hy If item 27 is marked oth or other traumatic event		19a. Informant's Name/Relationship (Type, Print)  Michael Stevens (Son)		ng Address (Street and N			-	ip Code)
αĵ	Healt Healt tem 2		Michael Stevens (Son)  20a. Method of Disposition	20h Place of Dispo	E. 94th St.			0c. Location - City or T	own, State
ē	Pages ent of nt: if i		1 A Burial 2 ☐ Cremation 3 ☐ Removal from St. 4 ☐ Donation 5 ☐ Other (Specify)		Mem. Park	10/6/	07	Farmingdal	e, NY
Baitimore,	permit. Pages Department of the Important: If ite any injury or of once.		21. Signature of Furneral Service Licens	22	Name and Address of F	acilio Chape	1		
	8 Q E 2 9		& Lannie Vellen	mere 1	236 Wellwoo	d Ave.,	West B		
			23a. Part1. Enter the disease, or complications that cau shock, or heart failure. List only one cause on each immediate Cause (Final	sed the death. Do not ent h line.	er the mode of dying, suc	ch as cardiac o	r respiratory arres	st,	Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	as a consequence of):					
	Examiner	U	Pil	monard	Edoma				UNK
	P #	iner	s unfaity list continue if any, leading to immediate cause. Enter Underfying Cause (Disease or injury	as a consequence of :					
	xecute and Il-tran	Examin	that initiated events	as a consequence of):					
9/60	death certificate be executed e attending physicien and od for use as the burial-transit	calE	d						
9	ntificating physical pass the		IF FEMALE:						
ROX	eath certifica attending ph I for use as th	lan/I	23b. Was decedent pregnant in the past 12-months?	n 2 ☐ Fetal death 3 ☐	Ectopic pregnancy			23d. Date of delin	very Day Year
	the de y the a ched f	Physician/Med	1 ☐ Yes 2 🐴 No 4 ☐ Pregnar 9 ☐ Unknown 9 ☐ Unknown		Other (specify)				
7. J	law requires that the deatt as been signed by the atte 2 should be detached for	by Pt	Part II. Other significant conditions contributing to dea	th but not resulting in the u	nderlying cause given in f	Part I.	23e. Did toba	acco use contribute to	the cause of death?
ğ	w require been sig should b					<del></del>	1 ☐ Yes	s 2□No 3□Pro	bably 4 🕅 Unknown
Vital Records,	alaw r has be e 2 sh	Completed					24a. Was an autopsy	prior to c	opsy findings available ompletion of cause of
<u>a</u>	Physician: The lav this certificate has al director, page 2							No 1 ☐ Yes	2□ No
	Physician: this certific ral director,	To Be	25. Was case referred to medical examiner?  1 \( \subseteq \text{Yes} \) 2 \( \overline{\text{No}} \) No Hospital: 1 \( \overline{\text{M}} \) Inp	atient 2 ER/Outpatien	Other		Check only one	nce 6 Other (Spec	why)
			27. Manner of Death 1 Natural 5 Pending (Month,				8d. Describe how		
<u>S</u>	or Attending Fatter death. Director: After in by the tuner.	cati	2 Accident investigation		M 1 ☐ Yes				
Division	4 ∵ 8 5	Certification:	determined 200. Flace U	Injury - At home, farm, str , etc. (Specify)	eet, factory, office	2	28f. Location (Str. City or Town,	eet and Number or Ru State)	rai Houle Number,
	To the Mospital or, within 24 hours after To the Funeral Director completely filled in E		29a. Certifier 1 X Certifying Physician: To the b	est of my knowledge, death	n occurred at the time, da	ate and place, a	and due to the car	use(s) and manner as	stated.
	the H iin 24 the Fu	ledical	(Check only 2 Medical Examiner: On the bas and manne	is of examination and/or in r stated.					
`	Veit To To	Σ	29b. Signature and title of dertifier	/	29c. License num	(12C		d. Date signed (Month	Day, Year)
7	1		30. Name and address of person who completed causes	of death (Item 23a) (Type	Print)	WX ()		7/00/	UT
	2		Kari Scantleburi, M.D.	1	Hospital D	r., Che	everly.	MD 20785	
6	Sta			istrar's Signature	and a	, 0.110			· · · · · · · · · · · · · · · · · · ·
	Registi	ar	OCT 1 0 2007	1183 AS 140	WAR				

07-07593 Joseph Lee Stev		State of Maryland 7 Separation of Fredhald and Member 1990	6
		Registrar Certificate of Death Reg. No.	_
Physicia Medical Exami		1. Decedent's Name (First, Middle, Last) Joseph Lee Stephenson  2. Date of Death Month Day Year September 27, 2007  3. Time of Death 1130 hrs	
wedical Exami	ner	4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death  4c. County of Death	_
₹		1703 Wilkens Avenue  Baltimore  N/A	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or	_
Director		516-62-7172 X M 2 F 55 Yrs. Months Days Hours Min. Feb. 15, 1952 Foreign Country) NC	
	1	Usual Residence of Decedent	_
w any		10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limit	
land f shov	ctor	MD N/A Baltimore 1X Yes 2 N	0
Mary r 28a- ed at	Direct	10e. Street and Number 10f. Zlp Code 10g. Citizen of What Country?	
th the 23a or	اڃَ	1703 Wilkins Avenue 21223 USA	
tems st be	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 1 Never Married 2 Married 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc.	
ter de:		Ves 2v No     African	
urs afl tural	d by	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry	_
72 ho 72 ho al Ex.	ete	Elementary/Secondary (0-12) College (1-4 or 5+) during most of working life. DO NOT use retired)	
21215-0036 uld be filed within 7 Mental Hygiene. marked other than e event, the Medica	Completed	10th Mechnic Self	
15-0 iled v Hygir d other		17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Maiden Surname)	
121 d be f fental narke	Be c	John C. Stephenson Odessia Darden  19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)	_
MD 2 d 2 shoul Jth and M n 27 is m	ဥ	Curtis Stephenson/Brother   5413 Hutton Ave, Baltimore, MD   21207	
and 2 lealth tem 2		20a, Method of Disposition	
IOTE iges I it of F it: If i		1 Burial 2 Cremation 3 Removal from State crematory or other place)	
Baltimore, MD 21215-0036  permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene and Inportant: If item 27 is marked other than "matural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.		4 Donation 5 Other Specify Mt. Zion Cem. 10/3/07 Lansdowne, MD  21. Signature of Pun ral Service Licensee 22. Name and Address of Facility	_
Ba Deprin		Hari P. Close Funeral S.P.	, A
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  5126 Belair Rd Ralt MD 21206-5105  Approximate Interv Between Onset an	
/Medical xaminer		Immediate Cause (Final disease a. Complications of chronic ethanolism	u
\ \alliniei		or condition resulting in death)  Due to (or as a consequence of):	
	-E	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):	_
	xamine	Courses or injury that initiated C.	
# # # d/11		events resulting in death) Last Due to (or as a consequence of):	
e executed in and in an and in an and	calE	d. V AMENDED	-
60, e be e ysiciar burial	edi	UNPENDED X AMENDED #1, perME, g872, 10/12/07 TT	_
Box 68760 death certificate b the attending physi	sician/Medical	FEMALE: 23c. If yes, outcome of pregnancy   23d. Date of delivery   23b. Was decedent pregnant in the past 12 months?   1 Live birth 2 Fetal death 3 Ectopic pregnancy   Month Day Year	
ox 6 ath cer attendi	Sicia	4 Pregnant at time of death 5 Other (Specify)	
. BC he de: y the s	Phys	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death?	
P.O. es that the gened by	ģ	1 Yes 2 No 3 Probably 4 V Unknown	ก
of Vital Records, P.O. Box 68760, in physician: The law requires that the death certificate be execute. After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial - tran	Completed	24a. Was an 124b. Were autopsy findings availab	ole
COT law re has be	ng e	autopsy prior to completion of cause of performed? death?	f
Re( The ficate	S	1 Yes 2 No 1 Yes 2 No	_
of Vital Records, ng Physician: The law requir ther this certificate has been a	Be	25. Was case referred to medical examiner?  1	
of V Phys rer thi	_T	1 V Yes 2 No	_
on C	ion	27. Manner of Death  28a. Date of Injury (Month, Day, Year)  28b. Time of Injury 28c. Injury at Work?  1 Yes 2 No	
Division tal or Attendi rs after death.	ertification:	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City Town, State)	ity
Div ital or urs aft	erti	3 Suicide 6 Could not be determined (Specify)	
Division of Vital Records, P.O. Box 68760, vitin 24 her tespital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeval Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buri.	alC	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	
Fo the vithin Fo the omple	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	
- > - 0	5	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)	

State 31. Date filed (Month, Day, Year) gistrar OCT 1 0 2007 Registrar DHWH 17 Rev 1/2001 OCME 2006

Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

30. Name and address of person who completed cause of death (Item 23a)

> 29c. License number O.C.M.E.

29d. Date signed (Month, Day, Year)

September 28, 2007

			For State Registrar	State of	Marylan	d / Depa	artment of F	lealth and N Death		giene 0	07	32369
			Decedent's Name (First, Middle	e, Last)					2. Date of De	ath	V	3. Time of Death
	Physicia /Medic		Hazel Delores	Smith				Month /D	4 a	7007	700AM	
1	Examin		4a. Facility Name (If not institution	4b. City, Town, or	Location of Death		4c. County					
			BELAIR HEALTI	tand REH	BEL A.	IR		HAI	RFOR	20		
	Funeral		5. Social Security Number	6. Sex 1 ☐ M 2 💆 F	7. Age (In yrs.		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	th ly, Year)	9. Birthp	place (State or Foreign
	Director		213-18-0130	TUM ZZIF	83	Yrs.			03/05/	1924		yland
	and w		Usual Residence of Decedent  10a. State 10b. County		10c. Cit	y, Town or Lo	cation			<u>-</u>	1	Od. Inside City Limits
	Manyl f sho	5	MD Harris									1 ☐ Yes 2X No
	28a-	Director	MD Harf	ora	Ве	l Air	10f. Zip Code			10g. Citizen of	What Cour	ntrv?
	3e or			Dood			21015			U.S.A.		
	me 2:	Funeral	621 Plumtree  11. Marital Status	12. Was Dece		.S. 13.	Was Decedent of H	ispanic Origin? (Sp	pecify Yes or No	- 14. Rad	ce - Americ	
9	within 72 hours after death with the Maryland ene. then "neturel", or Iteme 23e or 28e-f show ha Madical Exeminer must be multied at	교	1 Never Married 2 Marr	Armed For ied 1 ☐ Yes	2 <b>X</b> No		f Yes, specify Cuba		Rican, etc.)		ck, White,	etc.
<u>ල</u>	rel', c	l by	3 ☐ Widowed 4 ☐ Oivorced	If Yes, Give Year or Da			1 ☐ Yes 2 🛣 No	Specity:		Specif	y: Wh:	ite
2	72 h	Completed	15. Deceden (Specify onfy highe:	t's Education st grade completed)		(Give	tent's Usual Occup	during most of work	king	16b. Kind of B	usiness/Ind	dustry
2	ithin	n jd	Elementary/Secondary (0-12)	College (1-	4or 5+)	life.	DO NOT use retired	1)	3			
7	led w tygier her ti	S	10	1		Hom	emaker	40. 14-15-4-11-	· /5:		Home	
and and	be fi	Be	17, Father's Name (First, Middle,					18. Mother's Nam			_	
Ž	d Mer d Mer mark	ဥ	Henry Harrison  19a. Informant's Name/Relations			10h Mailie	ng Address (Street			ie Chafi		Cadal
Maryland 21215-0036	d 2 s th an t7 ls				. 51							
	Heal Heal tem 2		Cecil E. Smit 20a. Method of Disposition	h (husbar	20b. P	lace of Dispo	Plumtrec		Date Date	20c. Location		
ē	eges ant of it: if i		1 XBurial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		tate		natory`or other plac emorial (	1 .	8/2007	Bel Air	r Ma	ryland
Baltimore,	permit. Peges 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other then "naturel; or iteme 23e or 28e-f show with injury or other treumatic event, the Modical Examinat must be notified at anote.		21. Signature of Funeral Service		1							Home, P.A.
ä	Depa Impo eny i		> E 3!(	Lacas	2ms		1750 Bela					
H			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that ca only one cause on ea	used the deat ich line.	h. Do not ent	er the mode of dyin	g, such as cardiac	or respiratory a	rrest,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	-a. Ac	Wana	ed 1	Doing.	20				Oliset and Death
	/Medical Examiner		resulting in death)	Oue to (	or as a conseq	uence of):	Porner	1111				
		-	Sequentially list conditions, if any, leading to immediate  b. Tallufe 'To 'Thrile  Due to (or as a consequence of):									
	De Les	Examiner	cause. Enter Underlying Cause (Disease or injury	201100 01/1								
<u>,</u>	al-tra	Exal	that initiated events resulting in death) Last	C. Due to (	or as a conseq	uence of):						
8760,	cate be executed physicien and the burial-transit	dical		( d								
9	tificat ig phy as th											
Box	th cer endir r use	J/NE	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, out	ome of pregnanth 2 Feta		Ectopic pregnancy	,			ate of delive	1
<u>.</u>	The law requires that the death certific ete has been signed by the ettending f page 2 should be deteched for use as	Physician/M	in the past 12 months? 1 Yes 2 No		ant at time of d		Other (specify)			Mo	onth	Day Year
P.0.	et the 1 by th stech	Phy	9 Unknown	1								
	igned bed	þ	Part II. Other significant condition	ons contributing to de	ath but not res	ulting in the u	nderlying cause giv	en in Part I.		_/		he cause of death?
5	w requir been si should	ted	- Coro via	ry Ar	Tery	1	Sease		10	Yes 2⊟No	3 [] Proc	oably 4 ∐Unknown
ec	e 2 sl	Completed			/				24a. Was auto	psy	prior to co	ppsy findings available impletion of sause of
E	: The	ပိ							pend 1 ☐ Yes	ormed?	death? 1 ☐ Yes	24 No
<u> </u>	ician certifi ector	Be	25. Was case referred to medica examiner?	Hospital:			Oth	26. Place of Dea	th (Check only	one)		
5	Phys rthis raldi	요	1 Yes 2 TNo  27. Manner of Death	1 □ Ir		ER/Outpatier 28b. Time o	IL 3 DOA	A Nursing H		how injury occur		(v)
on	ding th. Afte	ţi	Natural 5 Pendir 2 Accident investi	ig (Monti	n, Day Year)	Injury	Wor	k?` Yes 2 □ No	254. 5030100	now inquity occur		
Division of Vital Records,	or Attend efter death Director:	fica	3 ☐ Suicide 6 ☐ Could	not be	of Injury - At h	ome, farm, str	eet, factory, office		28f. Location (	Street and Num	ber or Rura	al Route Number,
á	s efte	Certification:	4 Homicide	buildir	ig, etc. (Specif	<i>(</i> y)			City or To	wπ, State)		
	To the Hospital or Attending Physician: The law within 24 hours eller death. To the Funeral Director: After this certificate hes completely filled in by the funeral director, page 2	Medical (	(Check only 2   Medical	ng Physician: To the Examiner: On the ba	sis of examina	owledge, death	h occurred at the tir vestigation, in my o	ne, date and place pinion, death occu	, and due to the rred at the time,	cause(s) and m date and place.	anner as s	stated. o the cause(s)
	ro the	Med	one) 29b. Signature and title of certifie	and mann	er stated.		29c. Licens			29d. Date signe		
	- >- 0		) M A-	m In	()		m Di	9583		Dotal	06	/L 7607
	7		30. Name and address of person	who completed caus	d death (Iten	n 23a) (Type,	Pfint)	011	Ct.	+ 101	JEK .	T, SUUT
	/		Manuel	Lazah	Xr	17	N	hay	> Ire	San	and	2001
	Sta		31. Date filed (Month, Day, Year)	32. R	egistrar's Signa	ature form	W A	UE TOPEC	7	1017	W 1710	100
	Registr	ar	OCT 1 0 20	107		17						

SMITH

HAZEL

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

			1- State of Mary Registrar	•	artment of F rtificate of I		, ,	2007	32370		
A	Dhyaisi	12	1. Decedent's Name (First, Middle, Last)				Date of Death     Month	Day Year	3. Time of Death		
	Physici /Medic			Schroedei	c		October	5, 2007	5:45 p <sup>M</sup>		
10 A	Examin	er	4a. Facility Name (If not institution, give street and number)			Location of Death		4c. County of Death			
24			Chapel Hill Nursing Home  5. Social Security Number 6. Sex 7. Age (In	n yrs. last birthday)		llstown If Under 24 Hrs.	8. Date of Birth	Balti			
b	Funeral Director		402-12-9187 1□M 2⊠F 84	Vro	Months Days	Hours Min.	(Month, Day, Ye	ear) Co	hplace (State or Foreign buntry) irginia		
	pui »		Usual Residence of Decedent	c. City, Town or Lo	nation						
	Maryle f sho	ō	MD Baltimore			_			10d. Inside City Limits 1 ☐ Yes 2X No		
	the l	Director	10e. Street and Number	Kai	ndallstown	1	10g.	Citizen of What Co	ountry?		
	h with		3905 Falls Run Road		21133			U.S.A			
	ems (	Funeral	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto								
920	ges 1 and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental Hygiene. If item 27 is marked other than "natural", or Items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	by	1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		1 □ Yes 2 No	Specify:	riiodii, oto.)	Specify:	White		
21215-0036	72 ho natur dical l	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Dece	dent's Usual Occup	ation	16t	. Kind of Business/			
121	vithin nne. han "	mple	Elementary/Secondary (0-12) College (1-4or 5+)		kind of work done of DO NOT use retired		,,,g				
7 0	filed v Hygie ther t		10 17. Father's Name (First, Middle, Last)		<u>Homemakeı</u>		(First, Middle, Mai	Own Ho	me		
Maryland	ld be ental ked o	To Be	Daniel Scott			Cora		elford			
ary	2 should I and Men is marker raumatic	-	19a. Informant's Name/Relationship (Type. Print)	19b. Mailir	ng Address (Street a		al Route Number, Ci		Zip Code)		
	1 and 2 Health a em 27 is		Donald F. Schroeder Husband	3905	Falls Rur	n Road Ra	andallsto	wn, MD 2	1133		
ore	of He	1	20a. Method of Disposition 2 1   Burial 2 □ Cremation 3 □ Removal from State 2	20b. Place of Dispo cemetery, crei	osition (Name of matory or other place	e) [		Location - City or	Town, State		
Baltimore,	Pages tment of I tant: If ite		4 □ Donation 5 □ Other (Specify)		Forest V		1/07 Ow	ings Mill	ls, MD		
Baj	permit. Pages 1 an Department of Heal Important: If item 2 any injury or other		21. Signature of Funeral Service (Icensee		2. Name and Addres	. 1	1824 Reis				
e.		-	23a, Part1. Enter the disease, or complications that caused the				Reisterst		21136 Approximate		
	Physician	w n	23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line.     Immediate Cause (Final	1 . 1	**********	g, odom do odrado c	respiratory arrest,		Interval Between Onset and Death		
	/Medical		disease or condition resulting in death)  a. Due to (or as a co	nsequence of):	on						
E	Examiner		Sequentially list conditions b. Deme	entea							
	si ti	iner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury	nsequence of):							
	and and	Examiner	that initiated events resulting in death) Last  C  Due to (or as a col	nsequence of):							
68760,	death certificate be executed e attending physician and d for use as the burial-transit	alE	d								
89	tificate g phy as the	edical	U.	.0.							
Š	th cer rendin	an/N	IF FEMALE: 23b. Was decedent pregnant in the proof 12 months? 23c. If yes, outcome pf pr 1 ☐ Live birth 2 ☐		∃Ectopic pregnancy			23d. Date of deli	ivery		
O. B	The law requires that the death cerate has been signed by the attendir oage 2 should be detached for use	Physician/N	in the past 12 months? 1 □ Yes 2 □ 10 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		Other (specify)			Month	Day Year		
P.O	that the		Part II. Other significant conditions contributing to death but no	ot resulting in the u	nderlying cause give	en in Part I	23e Did tohace	o use contribute to	the cause of death?		
Records,	uires tha	d by	7	rder		on in Functi.	1 ☐ Yes		obably 4 □Unknown		
õ	w require been signature should b	lete	V				24a. Was an	24h Were au	topsy findings available		
	The lav	Completed					autopsy performed	prior to death?	completion of cause of		
Vital		BeC	25. Was case referred to medical examiner?			26. Place of Death	1□ Yes 2 (Check only one)	No 1 Li Yes	2 No		
	Physic this ce	2	. —	2 ER/Outpatien		4 Wursing Hor	me 5 ☐ Residence	e 6 □Other (Spec	cify)		
Division or	Attending Physician: r death. ector: After this certific by the funeral director.		27. Manner of Death 1 Natural 5 □ Pending (Month, Day Yea	ar) 28b. Time of Injury	Work		28d. Describe how in	njury occurred			
<u>s</u>	il or Attending P after death. I Director: After i d in by the funere	icati	2 Accident investigation 3 Suicide 6 Could not be 28e Place of injury.	At home farm etr		/es 2 □ No	Of Location (Ctross	t and Mumber as D.			
2	al or A after Il Direct	Certification:	4 Homicide determined 28e. Place of injury - building, etc. (S)		28f. Location (Street City or Town, S	tate)	rai noute Number,				
	Hospi 4 hou Fune ely fil		29a. Certifier (Check only and American Check only (Check only and American Ch	ne, date and place, a pinion, death occurr	and due to the cause ed at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)				
	To the l within 2 To the I complet	Medical	one) and manner stated.  29b. Signature and tille of certifier		Date signed (Month						
	⊬≯Fŏ		Halaas		Das l		10	108/20	26.7		
	5	ŀ	30. Name and address of person who completed cause of death	(Item 23a) (Type,			+	Suite	01		
			Tahoora Kawaja	20,0	C70SSYO	ads. D	rine	ind al	tills MAZINT		
	Sta		31. Date filed (Month, Day, Year) 32 Registrar's S					73	,		
	Registr	ar	OCT 1 0 2007 /	Jr April	ule)			~			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2007 32371 Roshon Cherez Smith Certificate of Death Reg. No 1- For State 2. Date of Death Registrar Decedent's Name (First, Middle,Last) October 5, 2007 2310 hrs Physician/ Smith Roshon Cherez ¬I Examiner c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Prince George's Seat Pleasant North Block 1100 Block Hill Road 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number DC **Funeral** Days 8/3/1984 Months Country) 23 212-13-5561 1X M 2 F Director Usual Residence of Decedent 10d. Inside City Limits IOc. City, Town or Location 10b. County any 10a, State 1X Yes 2 No Pleasant Seat P.G. MD items 23a or 28a-f show ust be notified at once. 10g. Citizen of What Country? it. Pages 1 and 2 should be filed within 72 hours after death with the Maryland rtment of Health and Mental Hygiene. retait: If item 27 is marked other than "natural", or items 23a or 28a-f sho y or other traumatic event, the Medical Examiner must be notified at once y or other traumatic event, the Medical Examiner Director 10f. Zip Code 10e. Street and Number U.S.A. 20743 6402 Greig Street Race - American Indian, Black, Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Funeral White, etc. 1 X Never Married 2 Married Armed Forces 2 X No Black Yes Specify: Yes 2 X No specify: Divorced If Yes, Give Year Widowed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 2 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed College (1-4 or 5+) Private Elementary/Secondary (0-12) Student 3 21215-0036 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Shorter Marie Rose Michael Anthony Smith Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print ) Eugenes Prospect Dr.Bowie, MD 20720 Michael A.Smith/Father Baltimore, MD 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Landover, MD 10/13/07 Harmony Mem.Cem. Important: injury or otl Donation 5 22. Name and Address of FacilityRona d Tay or II Funeal Hm. Other Specify 21. nature of Funeral Service Licensee 108 West N.Ave.Baltimore, MD 21201 ponald 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Between Onset and Physician Death failure. List only one cause on each line. Medical a. Multiple Injuries Immediate Cause (Final disease \_xaminer Due to (or as a consequence of): or condition resulting in death) Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Finterial Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit Physician/Medical AMENDED UNPENDED 23d Date of delivery Box 68760, 23c. If yes, outcome of pregnancy IF FEMALE Year Day 3 Ectopic pregnancy 23b. Was decedent pregnant in the Fetal death Live birth past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. Yes 2 ✔ No 3 Probably 4 Unknown þ 24b. Were autopsy findings available 24a, Was an Completed Division of Vital Records, prior to completion of cause of autopsy death? performed? 2 No 1 🗸 Yes ✓ Yes 2 26.Place of Death (Check only one) 25. Was case referred to medical Other<sub>4</sub> Residence 6 V Other: Scene Be Nursing Home 5 examiner? Hospital: 1 ER/Outpatient 3 Inpatient 1 Yes 28d. Describe how injury occurred 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) FOUND: 28b. Time of Injury Ejected driver of auto fixed object collision 27. Manner of Death Yes 2 V No FOUND: Certification: Natural Pending Oct 5, 2007 2301 hrs 28f. Location (Street and Number or Rural Route Number, City Investigation 2 🗸 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State) North Block 1100 Block Hill Road, Seat Pleasant, MD Could not be 3 Suicide (Specify) Major Road / Highway determined Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical one) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier October 6, 2007 7 O.C.M.E. 30. Name and add use of person who are letted in or death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Deputy Chief Medical Examiner DCME Mary G. Ripple MD. 32. Registrar's Sidpature

State Registrar

31. Date filed (Month), Pay Cear 2007

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2007 32372 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 10 05 05 2007 Willie Samuels 1:00 AM 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Sandtown-Winchester Nursing Home Baltimore If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Months Days Hours 1 M 2 ☐ F 97 unk 218<del>-</del>09-8113 April 8, 1910 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 Yes 2 No Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1000 N. Gilmor Street 21217 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status unk Black, White etc. American 1 ☐ Yes 2 ☐ No unk If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify. Specify: 3 Widowed 4 Divorced 16b. Kind of Business/Industry unk Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) unk Elementary/Secondary (0-12) College (1-4or 5+)

18. Mother's Name (First, Middle, Maiden Surname)

unk

Approximate Interval Between Onset and Death

Day

2 No

MO

21215

29d. Date signed (Month, Day, Year)

BALTIMORE

10

Year

2 should be filed within 72 hours after death or and Mental Hygiene.
Is marked other than "natural", or items 23s Baltimore, Maryland 21215-0036 other traumatic event, the M-dical Pages 1 and 2 s ment of Health an permit. Pages 1 and 2.
Department of Health a Important; if Item 27 is any injury or other trauonce. Physician

Physician

/Medical

Examiner

10a. State

MD

17. Father's Name (First, Middle, Last)

**Funeral** 

Director

r 28a-f show notified at

"natural", or items 23a or dical Examiner must be

with

Director

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Completed

/Medical Examiner death certificate be executed

Box 68760

P.O.

Division or Vital Records,

Examine attending physician and for use as the burial-transit Physician/Medical signed by the a \$ been si should Completed s certificate has balirector, page 2 s To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, Be P Certification:

19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia Overstreet / Friend 1000 N. Gilmor Street; Baltimore, Maryland 21217 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Mount Zion Cemetery 10/09/2007 4 □ Donation 5 □ Other (Specify) Baltimore, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Wylie Funeral Home, P.A. 638 N. Gilmor Street; Baltimore,MD 21217 23a. Part1. Enter the disease, or domplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) END STRGE ALZEHMER DEM ENTIA Due to (or as a consequence of): PNEUMONIA Sequentially list conditions, if any, leading to minimize the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) MMINUTRITION Due to (or as a consequence of): ACUTE RENAL IF FEMALE 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 ☐Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Anzemiz. 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? 1∏ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Natural 28a. Date of Injury 28h Time of Injury at Work? 28d. Describe how injury occurred (Month, Day 5 ☐ Pending investigation М 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Fortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

unk

State Registrar

Medical

ADEYEMISI 31. Date filed (Month, Day, Year) OCT 1 0 2007

29b. Signature and title of certifier

2600 SUSKNYA, M.D LIBBLIT HELLITIS NE 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

29c. License number

000614

Division or Vital Records, P.O. Box 68760 Hospital or Attending Physician: within 24 hours a To the Funerel I

Medical State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. DAVID DUNN

and manner stated.

615 W. MACPHAIL ROAD - SUITE 106 - BEL AIR, MD 21014 32 Registrar's Signature 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

29c. License number

D35522

29d. Date signed (Month, Day, Year)

2007

Celiler 8

			1 - State Registrar		Certif	cate of L	Death		Reg. No	2007	32374
F	Physici	an	1. Decedent's Name (First, Middle, Last)					2. Date of De Month		y Year	3. Time of Death
	/Media		Dorothy M.					oct.		007 Year	6:00 AM
	Examir	er	4a. Facility Name (If not institution, give s	·	4b		Location of Death			. County of Death	
			507 Chalcot Sq 5. Social Security Number 6. Sex		birthday) If	Esse: Under 1 Year	X If Under 24 Hrs.	8. Date of Bir	th	Baltimo	re ace (State or Foreign
	Funeral Director		217-18-5169	M 2XIF 83		onths Days	Hours Min.	May 2	3 , 1	924 Geo	rgia
	and w		Usual Residence of Decedent  10a. State 10b. County	10c. City, To	own or Location	n				10	Od. Inside City Limits
	a-f sho	ctor	MD Baltim		Esse						1 ☐ Yes 2 🕍 No
	ath with the 23a or 28 ust be not	ral Director	10e. Street and Number 507 Chalcot Sq	uare	1	Of. Zip Code	221		10g. Cit	USA	try?
980	should be filed within 72 hours after death with the Maryland and Mental Hyglene.  marked other than "natural", or items 23a or 28a-f show marked other than "natural", or items 23b or 28a-f show matic event, the Medical Examiner must be notified at	by Funeral	11. Marital Status  1 □ Never Married 27 Married 3 □ Widowed 4 □ Divorced	2. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:		Decedent of His s, specify Cubar Yes 2 No	spanic Origin? (Sp n, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)	)-	14. Race - America Black, White, e Specify: Wh	
21215-0036	within 72 ho iene. than "natui the Medical	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) 12th	College (1-4or 5+)	(Give kind life. DO l	s Usual Occupa of work done d IOT use retired) Mana	uring most of work	ing	Jo	ind of Business/Ind hn Hopk ok Stor	ins
Maryland 2	be od o	To Be Co	17. Father's Name (First, Middle, Last) Walter McKelvi	•			18. Mother's Nam	e (First, Middle Bragg	, Maiden		
	s 1 and 2 should f Health and Men Item 27 Is marke other traumatic		19a. Informant's Name/Relationship (Type Herman Travers	Jr. /husband	-	•				or Town, State, Zip MD 212	,
altimore,	Pages 1 a nent of Hea int: If Item iny or othe		20a. Method of Disposition 1   ☐ Burial 2 ☐ Cremation 3 ☐ R	emoval from State HOT	of Disposition tery, cremato Ly Hi	Name of ty or other place LI Cem	etery 1	Date 0/11/0	20c. Lo	ocation - City or To	wn, State e MD
Baltin	permit. Pages Department of Important: If It any injury or o		4 □ Donation 5 □ Other (Specify)  21. Signature Funeral Service Licen	Pollo		me and Addres	3			ve. Bal Essex	
pl	Physician // // // // // // // // // // // // //	I Examiner	23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, it any leading to minimize cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence Du	Ao not enter the Ao not be of):  One of):  De of):  De of):	e mode of dying	g, such as cardiac	or respiratory a	errest,	3	Approximate Interval Between Onset and Death 7 5 years 20 years 20 years
.O. Box 68760,	at the death certificate be executed by the attending physician and tached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	3c. If yes, outcome pf pregnancy 1 ☐Live birth 2 ☐ Fetal dec 4 ☐ Pregnant at time of death 9 ☐ Unknown		ppic pregnancy er <i>(specify)</i>		-		23d. Date of delive Month	ry Day Year
<u> </u>	w requires that to be the control of	ρχ	Part II. Other significant conditions cor Chronic Obst	tributing to death but not resulting	-	ying cause give	n in Part I.	23e. Did 1	/	use contribute to th	e cause of death? ably 4 □Unknown
Vital Hecords,	The la ate has page 2	Completed				UIS C		24a. Was	-	24b. Were autop prior to con death?	osy findings available inpletion of cause of
<u> </u>	stan: ertifica ctor,	Bec	25. Was case referred to medical examiner?				26. Place of Deat				
o V	Physic this or ral dire	2	1 □ Yes 2 No			DOA Othe	4 ☐ Nursing Ho	-		6 □Other (Specify	)
000	nding F ith. r: After e funera	tion:	27. Manner of Death Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	o. Time of Injury	28c. Injury Work /I 1 □ Y	at ? ′es 2 □ No	28d. Describe	how inju	ry occurred	
DIVISION	after dea Directo	Certification:	3 Suicide 4 Homicide  3 Suicide 4 Homicide  4 Homicide  4 Could not be determined  28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)  28f. Location (Street and Number or Rural Route Num City or Town, State)								Route Number,
_	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Medical C	29a. Certifier (Check only one) Certifying Physical Certification Physical Certificati	ician: To the best of my knowled her: On the basis of examination and manner stated.	dge, death occand/or invest	curred at the tim gation, in my op	e, date and place, pinion, death occur	and due to the	cause(s , date an	) and manner as st d place, and due to	ated. the cause(s)
	To th within To the	Me	29b. Signature and title of certifier	/		29c. License	number		29d. Da	te signed (Month, I	Day, Year)
)	/		Jan J. Mul.	MD.		D00	5773	21	18	18/0	7
	'n		3. Name and address of rson who co	mpleted cause of death (Item 23a	a) (Type, Print	) 404-401	· Eastern	Bival, 9	£55e	+MD2	1221

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)
OCT 1 0 2007

			For State Registrar	State of Maryland /	Depa <i>Cer</i>	artment of H	ealth and M Death	lental Hygie		32375
	Physicia /Medic		1. Decedent's Name (First, Middle, Last) Shirley	Mae		Tubman		2. Date of Death Month 10-6-2	Day Year	3. Time of Death
	Examin	_	4a. Facility Name (If not institution, give so Future Care Canto			4b. City, Town, or Balt	Location of Death		4c. County of Dea	ath
	Funeral Director		5. Social Security Number 6. Sex 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	7. Age (In yrs. last b	irthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y	ear) C	rthplace (State or Foreign country)  N.C.
	how thow		Usual Residence of Decedent  10a. State 10b. County	10c. City, To	wn or Lo	cation				10d. Inside City Limits
	with the Ma a or 28a-f s be oxiting	Funeral Director	Md. NA  10e. Street and Number  1021 E. Lanvale		alti	more 10f. Zip Code 21202	)	10g	. Citizen of What C	•
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "naturel", or Items 23s or 28s-f show any injury or other traumatic event, the Modical Examination at Le notified at once.	by Funeral		2. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Was Decedent of Hi f Yes, specify Cubar 1 ☐ Yes 2 R No	spanic Origin? (Sp	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Wh Specify:	
21215-0036	within 72 hour ine. :han "naturel e Madical E.	Completed b	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0·12)	cation 16 completed) College (1-4or 5+)	(Give life. I	dent's Usual Occupa kind of work done a DO NOT use retired,	luring most of work	ing	Proffession	
and 2	be filed value Hygie of other tevent, In	Be	12th grade  17. Father's Name (First, Middle, Last)	NA Jacks	Driv	er	18. Mother's Name	e (First, Middle, Ma		
Maryland	2 should and Mer is mark sumatic	은	Clyde  19a. Informant's Name/Relationship (Type		b. Mailir	ng Address (Street a	and Number or Run		City or Town, State,	Zip Code)
altimore, N	Pages 1 and pent of Health It: If item 27 y or other to		Gwendora Jackson  20a. Method of Disposition  1  Burial 2  Cremation 3  R  4 Donation 5 Other (Specify)	9)	et, Balti Date 20 10-07	.more, Md c.Location-City o Dundalk	r Town, State			
Balti	permit. F Departm Importer any injur		21. Signature of Funeral Service License	420.2		Name and Addres		March F.H , Baltimo	I. East ore, Md.	21202
	Physician		23a. Part1. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final	g, such as cardiac	or respiratory arres	t,	Approximate Interval Between Onset and Death			
	/Medical Examiner	iner	disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, Disease or injury.	Rheumes	Due to (or as a consequence of):  Rhenned id antrits  Due to (or as a consequence of).					
8760,	cate be executed physician and the burial-transit	dicai Examiner	Cause (Disease or injury that initiated events resulting in death) Last	ue to (or as a consequenc	e of):	REV	ance			
.O. Box 68	the death certifi y the attending I ched for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	3c. If yes, outcome of pregnancy 1 □Live birth 2 □ Fetal dea 4 □ Pregnant at time of death 9 □ Unknown		Ectopic pregnancy Other (specify)			23d. Date of d Month	elivery Day Year
٥	uires that signed by	þ	Part II. Other significant conditions con	tributing to death but not resulting	in the u	nderlying cause give	en in Part I.			to the cause of death?  Probably 4 □Unknown
al Records,	: The law requires cate has been sign ; page 2 should be	Completed						24a. Was an autopsy performe	ed? death? No 1 ☐ Ye	
of Vital	Physicien: Th this certificate ral director, pag	To Be	25. Was case referred to medical examiner?  1  Yes 2 No	ospital: 1   Inpatient 2   ER/0	Dutpatier		er: 4 Chursing Ho	h <i>(Check only one)</i> ome 5 🗆 Residen		ресіfу)
ion o	ding h. After fune	ertification;	27. Manner of Death 1 Matural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	. Time o Injury	Worl	yat ⟨? Yes 2 □ No	28d. Describe how	injury occurred	
Division	in lite	Certific	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, building, etc. (Specify)	farm, str	reet, factory, office		28f. Location (Stre City or Town,	et and Number or i State)	Rural Route Number,
	To the Hospitel or At within 24 hours after of To the Funerel Direct completely filled in by	edical C		sician: To the best of my knowled her: On the basis of examination and manner stated.						
)	To the withing To the comp	M	29b. Signature and title of certifier	M.D		29c. License	o 5517	290	d. Date signed (Mo	nth, Day, Year)
	\		30. Name and address of person who co	11th 3023 (	-			Bothme	me MD	21224
1	Sta Registi		31. Date filed (Month, Pay Year) 20	32. Signature						

State of Maryland / Department of Health and Mental Hygiene 2 0 0 7 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 06,<sup>Day</sup>2007 Month **Physician** Donell Thomas 3:00 A <sup>M</sup> Oct. Simeon /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Towson Gilchrist Hospice Center Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 10.29.1924 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Months Hours 82 GA 254.26.9539 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State r 28a-f show notified at 1 ☐ Yes 2. No FL Wakulla Crawfordville Director 10f, Zip Code 10g. Citizen of What Country? 10e. Street and Number with r than "natural", or items 23a or the Medical Examiner must be r 50 Shadow Oak Circle U.S.A. · death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after obpartment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any Injury or other traumatic event, the Medical Examines 1 Xes 2 No If Yes, Give Year or Dates: WW 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: White 2 3 Nidowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Business Owner Paint Company 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Floy Donell Thomas Josephine Castleberry ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Glen D. Thomas/Son 16104 Carroll Road, Monkton, MD 21111

per of Disposition (Name of Date 20c. Location - City or Town, Sta 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 10.08.07 Chesapeake Crem. Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Cremation And Funeral Balto d Alternatives 8717 Green Pastures Dr. MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final with Physician ne disease or condition resulting in death) /Medical Due to or as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter the cause of the cause o Due to (or as a consequence of): Examine The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of) physician a Division or Vital Records, P.O. Box 68760, Physician/Medical attending pl 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No been signed by the should be detached 9□ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy 2∐No Hospital or Attending Physician: r this certific ral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Sans 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Vesidano P 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Medical Certification: 1 Natural (Month, Day Year) 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident within 24 hours after death

To the Funeral Director: / 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the h 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) and address of person who completed cause of death (Item 23a) (Type, Print) rles St. Bulto uns BMC 6761 N-32. Registrar's Signature 31. Date filed (Month, Day, Year) State OCT 1 0 2001 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Wardand Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Physician 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death Examiner SECOURS MORE Birthplace (State or Foreign Country) If Under 24 Hrs. 8. Date of Birth Hours Min. (Month, Day, If Under 1 Year 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 XF Director YIRGINIA Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 28a-f show 1 XYes 2 □ No Director MARVLAND 10g. Citizen of What Country? 10e. Street and Number be Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 0 1 ☐ Yes 2 🔼 No þ 3 X Widowed 4 ☐ Divorced "natural", th and Mental Hygiene.
It is marked other than "natural" Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) Be Freemon JEORGE 2 Hattie Amstrong 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health ar Important: If item 27 is any injury or other trau 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town. State Date 20a. Method of Disposition 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) BALTIMORE MARVLAND 4 ☐ Donation 21. Sign Jure of Juneral Service Licensee TON disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrests failure. List only one cause on each line. 23a. Part Enter the dis shock, or hear failu Immorate Caus Final dise se or condition resulting in death) PTICEMIA Physician /Medical **Examiner** Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospital or Attending Physician; The law requires that the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day 4□Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 No 3 Probably 4 Hinknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 NO 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation thours after death.

-uneral Director: Afely filled in by the full 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 0030355 30. Name and address of person who completed cause of death (flow) 23a) (Type, Print) 32. Registrar's Signature 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

State Registrar

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month EARL 06,2007 4c. County of Death CTOBER /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death BURNIE HEALTH AND KEHAB BURNIE GLEN ANNE ARUNDEL If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day) Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 218-26-437 1**X** M 2□ F Months Director Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits must be notified at 1XYes 2 □ No Director MARYLAND BALTI MORE OOKL 10e. Street and Number 10g. Citizen of What Country? 23a or Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. n "natural", or item fedical Examiner r Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 Never Married 2 Married 1 X Yes 2 ☐ If Yes, Give Year or Dates: 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No þ Specify: BLACK 3 ☐ Widowed 4 ☐ Divorced Completed ed other than "natu event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) ACCOUNTS INVESTIGATION C. item 27 is marked other other traumatic event, the 17. Father's Name (First, Middle, Last) Be ENR ٩ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition Department of Important: If it any injury or conce. 1 Burtal 2 Cremation 3 □Removal from State 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Agence BALTO, MD. 21217 FULTON 23a. 1. Enter to disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, suck, or hear railure. List only one cause of each line. Approximate Interval Between Onset and Death I kmc diate Cause (Final list ase or condition sulting in death) **Physician** WEEK NEUMONI /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner law requires that the death certificate be executed and burial-tran Due to (or as a consequence of): P.O. Box 68760, physician Physician/Medical the attending p as IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 2 No 3 ☐ Probably 4 ☐ Unknown peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No certificate has autonsy 1ABG TE Yes 2 NO 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 2010 ۵ 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA this 6 ☐Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural Hospital or Attendi 24 hours after death. Funeral Director; A 1 🗌 Yes 2 No 2 Accident filled in by the 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital of within 24 hours af To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TON 31. Date filed (Month, Year) Day, egistrar's Signature

DHMH 17 Rev 1/2001

Registrar

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician WASHINGTON OCTOBER 2007 11:40A M M. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HERITAGE CENTER BALTIMORE DUNDALK 8. Date of Birth (Month, Day, Year) If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 6. Sex 7. Age (In yrs. last birthday Days Months Hours 1 □ M 2 X 214-22-2534 Director MAY 15,1914 93 MD Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Fysical Process. 10a. State 10c. City. Town or Location 10b. County 10d. Inside City Limits Yes 2□No Completed by Funeral Director MD BALTIMORE TURNER STATION 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 642 N. AVONDALE ROAD 21222 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No Specify. Specify: 3 Widowed 4 Divorced BLACK 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) WAITRESS BETHLEHEM STEEL 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be CLAUDIE CLAPP 2 WILLIE ANN FLOOD 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) THORETTA BARNES/NIECE BALTIMORE, MARYLAND 5033 THE ALAMEDA 21239 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 10-16-2007 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) ARBUTUS MEM PK 22. Name and Address of Facility JAMES A. MORTON & SONS F.H., INC. 21. Signature of Funeral Service Licenses 1701-31 LAURENS ST. BALTIMORE, MD 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final MON **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregna 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 mon Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying car 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 3 Probably 4 Unknown 24a. Was an Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No perform 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2 No Other: ဥ 1 🗌 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred Natural (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical

Registrar

(Check only one)

31. Date filed (Month, Day,

and title of certifier

OCT1 0 2007

Year)

29b. Signature

DHMH 17 Rev 1/2001

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** Oct.7,2007 10:20am Walker Daisy /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** N/A Baltimore Keswick Nursing Center Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) June24,1913 Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days 1□M 2√F 258-32-2394 Usual Residence of Decedent 94 Georgia Director 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at angles. 10c. City, Town or Location 10a. State 10b. County 1 ☐Yes 2 ☐ No Director Baltimore MD N/A 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21213 U.S.A. Spring St. 1625 N. 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. M Never Married 2 Married Specify: Black 1 ☐ Yes 2 ☑ No Specify 3altimore, Maryland 21215-0036 3 ☐ Widowed 4 ☐ Divorced Completed by 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Balto. CityPublicSch. Dietition 7th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary Carter Charlie Walker ٥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2818 Ruscombe Lane Balto. MD 21215 WalterWalker/son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Arbutus MemPark Oct 12.2007 Baltimore MD 22. Name and Address of Facility CALVIN B. SCRUGGS FUNERAL HOME 1412 E. PRESTON ST. BALTIMORE, MD 21213 4 Donation 5 Dother (Specify) 21. Signature of Funera Approximate Interval Between Onset and Death Part1. Enter the disease, or complications that chashock, or heart failure. List only one cause on each sea me seath. Do not enter the mode of dying, such as cardiac or respiratory arrest Immediate Cause (Final disease or condition resulting in death) **Physician** Due to (or as a consequence of): Arten /Medical Examiner Unknown Aremis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Cerebroyesule led by the attending physician and detached for use as the burial-trans Due to (or as a consequence of) The law requires that the death certificate be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Year Month in the past 12 months? 1 ☐ Yes 2 No 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed to 1 ☐ Yes 2 ☐ No 3 ☐ Probably Unknown DEMENTIA 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No 24a. Was an autopsy performe has 1 Yes 21000 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 27. Manner of Death 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Division or Vital Records, P.O. Box 68760

within 24 hours after death.

To the Funeral Director: After this certifical completely filled in by the funeral director.

State Registrar

4 Homicide Medical (Check only one) 29b. Signature and title of certifier

3 ☐ Suicide

Saluja cet 31. Date filed (Month, Day, Year) 0

6 ☐Could not be determined

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2. Registrar's Signature

MO

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1600 West MT Royal Ave

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c License number

Donzaosto

29d. Date signed (Month, Day, Year)

10/8/07

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2007 Year **Physician** nice Oct. 5 12:25pM /Medical 4c. Counfy of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number, Examiner Baltimore Baltimore Brightwood Center / Genesis 8. Date of Birth 9. Birthplace (State or OCL 31, 1928 Mary land If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Days 1 □ M 2 ⋤ F 78 214-24-7314 Director Usual Residence of Decedent 10d. Inside City Limits 10c, City, Town or Location 10a, State 10b. County "natural", or items 23a or 28a-f show didal Examiner must be notified at 1 ☐ Yes 2 ☐ No Baltimore Director MD Essex 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1900 Grove MAnor Drive 21221 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White þ 3 □ Widowed 4 □ Divorced Completed the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 721 (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker own home 12th permit. Pages 1 and 2 should be filed a Department of Health and Mental Hygic Important: If Item 27 Is marked other any injury or other traumatic event, III 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Bertha E. Eaton Roland L. Hadel 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 55 Circle Drive York PA 17402 Earl L. Jones /son Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Oak Lawn Cemetery 10/9/07 20c. Location - City or Town, State 20a. Method of Disposition 1 Surial 2 □Cremation 3 □Removal from State 4 □Donation 5 □ Other (Specify) Baltimore MD 22. Name and Address of Facility 300 Mace Ave. Balto. MD 21. Signature of Funeral Service Licensee 21221 Connelly Funeral Home of Essex 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Chronic /Medical Due to (or as a consequence of): Examiner ronary Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner certificate be executed the burial-transit Hy no thy soids <u>₽</u> Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical as 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 No Month Day Year 5 ☐ Other (specify) 4☐Pregnant at time of death the detached 9 Unknown 9 Unknown signed by t I be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ☑ No 24a. Was an page 2 autopsy performed? certificate 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 48 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 25 No 1 Inpatient 2 ER/Outpatient 3 DOA P this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred al or Attending Patter death. After Certification: Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the ft 3 Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier Medical and manner stated. 29b. Signature and title of contifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

17

DHMH 17 Rev 1/2001

Oster Drive,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

7505

32. Registrar's Signature

JAYFM HIRFARM

31. Date filed (Month, Day, Year)

10-8-07

F Wagner,		Sta	te of Maryland				nd Mental H	Hygiene	20	07 222
<b>D</b>		Registrar  1. Decedent's Name (First, Middle,	l not)	Cer	tiricate c	of Death			. No. 20	07 323
Physicia lical Exami	2117		,					2. Date of Death Month September	Day Year	3. Time of Death 1614 hrs
		John Francis W. 4a. Facility Name (if not institution,	agn∈:r, Jr give street and number)			4b. City, Town, o	r Location of Dea		4c. County of De	
		St. Mary's Hospital				Leonardtov	vn		St. Mary's	
Funeral		Social Security Number 6	, Sex 7. Ag	e (In yrs. la	st birthday)		ar If Under 24H	The Control of the Co		Birthplace (State or
Director		226-27-4903 Usual Residence of Decedent	M 2 F	39	) Y	Months Da	ys Hours M	in. 08/16/	1968	reign CountryWash. DC
any		10a. State 10b. County		10c. City,	Town or Loc	ation			***	10d. Inside City Limits
and show	ᅵᅵᅵ	MD St. Ma	ary's		I	Lexingtor	n Park			1 Yes 2 XNo
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Huld and Mental Hygiene. Internet of I item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.	Director	10e. Street and Number				10f. Zip Code		100	. Citizen of What 0	Country?
h the	اقًا	46845 Morning	Dew Lane #	308		20653			U.S.A.	
th with	Funeral	11. Marital Status 1 X Never Married 2 Mari	12. Was Decedent Armed Forces?		S. 13. W	as Decedent of H Yes, specify Cuba	ispanic Origin? ( n. Mexican, Puer	Specify Yes or No-	14. Race - Ar White, et	merican Indian, Black,
or it	필		1 Yes 2	X No	۱.,–	_				
rs afte	<u>a</u>	3 Widowed 4 Divor	ced If Yes, Give Year or Dates:	anlatad\ I	160 Deced	Yes 2 Ne		funding dama	Specify: 1	White
2 hour	Completed	Elementary/Secondary (0-12)	College (1-4 or			most of working life				,
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ould!	의	John F. Wagne 19a. Informant's Name/Relationship	(Type, Print)		19b. Maili	ng Address (Stre	et and Number o	Fllen Dor Rural Route Numb	er, City or Town, S	tate, Zip Code)
d 2 sho d 2 sho lth and n 27 is numati		John F. Wagner	, Sr./Fathe	r	6203	Catalina	Drive,	Unit 736	, N Myrt	le Beach SC
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Dalumore, permit. Pages 1 ar Department of Hec Important: If ite		4 Donation 5 Other Spe	3 Removal from St	aic		Memoria]	Pk. 0	9/1.7/2007	Fairfa	ax, VA
mit. partm ports ury o		21. Signature of Funeral Service Li			22.	Name and Addres	7.6	urphy Fun		
E.E.Q.E.E	. 3	Matthew Buscher			11:	102 W. Br				VA 22046
d sit	Examiner	or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conset b.  Due to (or as a conset c.  Due to (or as a conset co	equence of	):					
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BOX BOY BU,  re death certificate be e  the attending physicia  red for use as the buria	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unkn	9 Ulikiluwii	time of dea	2 Fath 5 (	Other (Specify)	Ectopic preg		23d. Date of del Month	Day Year
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Physician: The law r r this certificate has b ral director, page 2 sh	O	examiner? 1 ✓ Yes 2 No	Hospital: 1 Inpatie		ER/Outpatie	nt 3 DOA	Other Nur	sing Home 5 F		ther:
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			1 _ State		artment of Health and I <i>rtificate of Death</i>						
		n	Registrar  1. Decedent's Name (First, Middle, Last)	061	Timeate of Death	Reg. No. 2007 3.238					
	Physicia /Medic		JOHN H.	W	ARREN	October	6 2007 1:53PM				
	Examin		4a. Facility Name (If not institution, give street and numb		4b. City, Town, or Location of Death  LANHAM		4c. County of Death PRINCE GEORGES				
	Funeral	-	DOCTORS COMMUNITY HOS  5. Social Security Number 6. Sex 7	. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs.	8. Date of Birth	9 Birthplace (State or Foreign				
	Director		225-52-8024 <sup>1⊠M 2□ F</sup>	66 Yrs.	Months Days Hours Min.	(Month, Day, Y 07-10-	1941 HOPEWELL, VA				
	land bw t		Usual Residence of Decedent           10a. State         10b. County	10c. City, Town or Lo	ocation		10d. Inside City Limits				
	Mary a-f sho	tor	MD PRINCE GEORGES	S SPRING	DALE		1 XYes 2 No				
	or 28	Director	10e. Street and Number		10f. Zip Code	10g	. Citizen of What Country?				
	sath w	eral	9100 ARDWICK ARDMORE		20785 Was Decedent of Hispanic Origin? (S	necify Ves or No-	U.S.A.  14. Race - American Indian,				
õ	iges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene.  If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	y Funeral	1 □ Never Married 2 Married  Armed Force 1 1 X Yes 2 If Yes. Give	DIT No	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerl 1 ☐ Yes 2 No Specify:	o Rican, etc.)	Black, White, etc.  Specify: BLACK				
21215-0036	thours atural" cal Exa	ed by	15. Decedent's Education	16a. Dece	dent's Usual Occupation	16	b. Kind of Business/Industry				
212	thin 72 e. an "na Medic	Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4)	4or 5+}	kind of work done during most of wor DO NOT use retired)						
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and	d be fi ental F ked otl	To Be	17. Father's Name (First, Middle, Last)  SYLVESTER	WARREN	MARY		WRIGHT				
Maryland	12 should be 1 n and Mental I r Is marked of raumatic eve	F	19a. Informant's Name/Relationship (Type. Print)				City or Town, State, Zip Code) 20785				
	1 and 2 Health em 27 I		SHIRLEY WARREN - WIFI	E 9100			SPRINGDALE, MD				
	Pages 1 nent of H int: If ite iry or ot		20a. Method of Disposition  1	tate cemetery, cre	matory or other place)		CHELTENHAM, MD				
Baltimore,	# <b># # #</b> # #		4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service Licensee		2. Name and Address of Facility T						
ñ	1/22 NORTH CAPITOL SI., NW WAS										
23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one dause on each line.  Physician  Physician  The fare the disease or condition  Description  Descri											
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s, P.O.	The law requires that the death certifate has been signed by the attending agge 2 should be detached for use a	by Ph	Part II. Other significant conditions contributing to dea	1	inderlying cause given in Part I.	23e. Did toba	cco use contribute to the cause of death?				
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or Vital Records,	e law r has be je 2 sh	Completed	Cevebro vascu	lar Dise	abe	24a. Was an autopsy performe	24b. Were autopsy findings available prior to completion of cause of death?				
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	the H	Medical	one) and manne 29b. Signature and title of certifier		29c. License number		I. Date signed (Month, Day, Year)				
	vit or	į.	Taw Twall	I I MU	D00426	<i>-</i> .	10/6/07				
Į,	41	. 3	30. Name and address of person who completed cause		Print)						
	11		JR Tay Zwally 575	Main Street	Laurel, mo	2070	7				
	Sta		31. Date filed (Month, Day, Year) 32. Re	gistrar's Signature	e of a						

DHMH 17 Rev 1/2001

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Armed   1   Yes   1   Yes   Year or or or or or or or or or or or or or	number)  d, Apt. 9  7. Age (In yrs. I 86  10c. City  ad, Apt.  Decedent Ever in U. I Forces?  ss 2 k No Give or Dates:  ed) e (1-4or 5+)	18 last birthday) Yrs.  y, Town or Loc Roc 918 S. 13. W If the Company of the Com	Ckville  10f. Zip Code  Vas Decedent of Hi Yes, specify Cuba  Yes 2 No ent's Usual Occup kind of work done of NOT use retired	20853  ispanic Origin? un, Mexican, Pur Specify: during most of will)	2. Date of De Month Septemath  s. B. Date of Bir (Month, De Doct. 25)  (Specify Yes or Noerto Rican, etc.)  Salvadora	Day  Day  Der 23,  4c. County  Mon  The street of V  Dec 14. Bac Blac  In Specification of B  Medical	y of Death  tgome 1  9. Birthple Counting E1 Sc  10  What Counts SA De - America ck, White, e y: Whit	ace (State or Foreign ry) alvador  od. Inside City Limits 1 Yes 2 No ry?  an Indian, etc.		
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n Benavides ation 3 □Removal fro her ( <i>Specify</i> )		19b. Mailing		Emilia	a Angulo		,			
ation 3 □Removal fro her ( <i>Specify)</i>			g Address (Street	and Number or	Rural Route Numb	er, City or Town,	, State, Zip (	Code)		
rvice Licensee	C+_+	Place of Dispos cemetery, crem e of He	604 Veirs sition (Name of natory or other place eaven Cen . Name and Addres rancis J	Ser netery	Date 28,	20c. Location	- City or Tov	ille, MD 20 wn, State g, Maryland		
ew a Col	e	- 1						g. MD 2090		
b. Due	to (or as a consequence to (or a) consequence to (or a) consequence to (or a) consequence to (or a) consequence to (or a) cons	uence of):						Approximate Interval Between Onset and Death		
7 1 Liv 7 4 Pre	ve birth 2 Peta regnant at time of d	al death 3 🗌		,		1		ry Day Year		
	o death but not resu	ulting in the un	nderlying cause give	en in Part I.				e cause of death?		
					- auto	ormed?	death?	osy findings available npletion of cause of 2 \( \) No		
Hospital:		(FD (0 )	Oth	Of:						
28a. Da	ate of Injury	28b. Time of Injury	28c. Injur Worl	y at k?				)		
latermined 200. Fit	ace of injury - At houlding, etc. (Specify	ome, farm, stre fy)	eet, factory, office	2,177.424	28f. Location ( City or To	(Street and Num wn, State)	ber or Rural	Route Number,		
dicai Examiner: On the	ne basis of examina									
	lew &	· nc)						-		
e wroll	_			er Mill	Road, Ro	ckville	, MD 2	20855		
	ponditions contributing to the dical Hospital:  Pending Physician: To dical Examiner: On the dical Examiner: On the dical Examiner on the dical Examiner on the dical Examiner on the dical Examiner: On the d	1   Live birth   2   Feta 4   Pregnant at time of conditions contributing to death but not respond to the death but not respond to t	Pregnant at time of death   3   4   Pregnant at time of death   5   9   Unknown   9	1	1	1	1	1		

DHMH 17 Rev 1/2001

07-07227 Richard Asare Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

chard Asare		1- For State	e of Maryland / [	epartmer <i>Certificat</i>			Mental I	Hygiene	Reg. No.	200	7 3238	
Physici	an/	Registrar  1. Decedent's Name (First, Middle,Li	ast)					2. Date of D Month		Year	3. Time of Death	
edical Exami	iner	Richard Kari			14. 6	ity, Town, or Lo		Septem	per 17, 20	07 ounty of Death	1119 hrs	
		4a. Facility Name (if not institution, g Johns Hopkins Hospital	live street and number)		l l	altimore	cation of Dea	atri	40.00	ounty of Death		
Funeral			Sex 7. Age (1	n yrs. last birthd			If Under 241	_	Birth (MM/DD		thplace (State or Foreign untry)	
Director		217 33 2207	X M 2 F	24	Yrs.	onths Days	Hours N	July	25, 198		Ghana	
any.	50 to 1	Usual Residence of Decedent  10a. State 10b. County	110	c. City, Town or	Location						10d. Inside City Limits	
≥	_	Maryland Anne	Arundel	,,		Glen Bu	rnie				1 Yes 2 x No	
Maryland 28a-f show 1 at once,	Director	10e. Street and Number			101	Zip Code			10g. Citizer	of What Cou	ntry?	
the N 3a or 3	Dir	8009 High O	ak Road			210				U.S.A.		
th with ems 2	uneral	11. Marital Status  1 X Never Married 2 Married	12. Was Decedent Ev	er in U.S. 1		cedent of Hispa pecify Cuban, N		Specify Yes or nto Rican, etc.)	No- 14	. Race - Amer White, etc.	ican Indian, Black,	
Baltimore, MD 21215-0036  permit, Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mehall Hygievier Important: If lieng 27 is marked other than "matural", or items 23a or 28a-f should injury or other transmatic event, the Medical Examiner must be notified at once.	111		1 Yes 2 X ed If Yes, Give Year	No	1 Yes	2 X No	snecify:		Black			
ours:af	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done								ecify: d of Business/	Industry		
6 172 hc an "nii cal Ex	Elementary/Secondary (0-12) College (1-4 or 5+) during most of working life. DO NOT use retired)							retired)		*		
within giene.	Completed	17. Father's Name (First, Middle, La	3	1		Student		me (First: Middl	a Maiden Su		ation	
215- e filed tal Hyj ked ot nt, the	Isaac Kobi Asare							Mother's Name (First, Middle, Maiden Surname)  Comfort Ayirebi				
21 nould be id Men is mar	O 19a. Informant's Name/Relationship (Type, Print ) 19b. Mailing Address (Street and Number or Rural Route Number of Rural Route Number or Rural Route Num								lumber, City	or Town, State	e, Zip Code)	
MC 2 sl afth ar mi 27		Comfort A. Asare 20a. Method of Disposition	Oak Roa (Name of ceme		Burnie,		d 21060 cation - City or	Tour State				
Ore, ges la tof He ther the		1 X Burial 2 Cremation		cremator	y or other p	lace)				•		
Itim iit Pa intmen ortant	- :- }	4 Donation 5 Other Spec 21. Signature of Funeral Service Do	ify:	Gate of		and Address o	_	0/06/2007	Sil	ver Spri	ng, Maryland	
Ba perm Depx Imp		Noney A To	con Tre		Hines	-Rinaldi	Funera	l Home, I Avenue, S	nc. ilver Si	oring. M	aryland 20904_	
Physician 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dyl								c or respiratory	arrest, shock	, or heart	Approximate Interval Between Onset and	
/Medical ¬xaminer		In mediate Cause (Final disease or condition resulting in death)	a. Multiple Gunshot								Death	
		Sequentially list conditions,	Due to (or as a consequent).	lence or).				*				
	iner	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a consequ	ence of):								
в	Examiner	(Disease or injury that initiated events resulting in death) Last	Due to (or as a consequ	ence of):								
60, ate be executed aysician and e burial - transit	<u> </u>		d		-						-	
60, ate be er hysician	Physician/Medical	UNPENDED  IF FEMALE:	* AMENDED #5perINF:10		.MbCb				234	Date of deliver	1	
68760, certificate be nding physici se as the buri	any	23b. Was decedent pregnant in the past 12 months?	1 Live birth	2	Fetal d	eath 3	Ectopic pre	gnancy			Day Year	
Box 687, deatl certificathe attending poor for use -s th	sici	1 Yes 2 No 9 Unkno	Wn g Unknown	ne of death 5	Other	(Specify)						
• 4 24	Ph.	Part II. Other significant condition		ut not resulting	in the unde	rlying cause giv	en in Part I.	23e. D	d tobacco us	e contribute to	the cause of death?	
s, P.O uires that to signed by d be detact	d by							_ 1	Yes 2	No 3 Pro		
ord: w requas beer	plet								itopsy	prior to	utopsy findings available completion of cause of	
Rec The la icate h	Completed								erformed? es 2 No	death? 1 🗸 Y	es 2 No	
ital iician: s certif rector,	Be	25. Was case referred to medical examiner?	Hospital: 1 Inpatient	2 ✔ ER/Out	notiont 2		of Death (Che	rsing Home 5	Residenc	ce 6 Othe		
of Vital Records, ng Physician: The law requir the this certificate has been s meral director, page 2 should I	<u>ا</u>	1 Ves 2 No 27. Manner of Death	I Impation		me of Injury			28d. Descri	be how injury			
	27. Manner of Death  1 Natural 5 Pending  28a. Date of Injury Sep 17, 2007  28b. Time of Injury 28c. Injury at Work? 1 Yes 2 No  28d. Describe how injury occurred Subject was shot											
Division tal or Attendins after death.  al Director: /	aging and the property of the									l Number or R g Lane, Balti	ural Route Number, City	
ospita hours uneral ly fille		4 Homicide determi	( Consumy) Loca			at the time date	o and place				-	
Division To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical	Check only Certifying Fires	sician: To the best of my k ner:On the basis of examin	nation and/or inv	estigation,	in my opinion,	death occurre	ed at the time, d	ate and place	e, and due to t	he cause(s)	
To Viit	Re	29b. Signature and title of certifier	and manner stated.	0		29c. License	number		29d. Da	ate signed (Mi	onth, Day, Year)	
(a)			M. 1/			O.C.M	I.E.		Septe	ember 18, 2	2007	
		30. Name and address of person will Jack Titus MD. Deput	no completed cause of dea by Chief Medical Exa		1 Pann (	Street Rollin	more MD	21201				
	tate	31 Date filed (Month Day Year)	32 Fenietrar's		- I GIIII S	Jucet, Dailli	THOIE, IVID			····		
Regis		SEP 25	2007 Segue	E-	4084	29						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2007 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** September 24, 2007 Mariana Abdelmanan Elvas Ali 7:20 A<sup>M</sup> /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner 10512 Lime Tree Way Beltsville Prince George's 8. Date of Birth (Month, Day, Yea March 29, 9. Birthplace (State or Foreign Country)
Egypt If Under 1 Year If Under Months Days Hours 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Year) 1□M 2XF Director 220-08-3917 60 1947 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show r 28a-f show notified at 1 ☐ Yes 2 No Director Maryland | Prince George's Beltsville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Pages 1 and 2 should be filed within 72 hours after death with "natural", or items 23a or edical Examiner must be r 20705 United States 10512 Lime Tree Way Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: Specify: White <u>م</u> 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) the Me College (1-4or 5+) Elementary/Secondary (0-12) 12 Home Maker Own Home event, the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be and Mental 27 Is marked c Zeinab Mohamed Abdelwahab Abdelmanan Elyas Ali 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10512 Lime Tree Way 19a. Informant's Name/Relationship (Type. Print) f Health a Beltsville, MD 20705 Mahmoud I. Kamal- husband Date 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages
Department of I
Important: If Its
any Injury or o
once. Sep. 24, 1 Burial 2 □ Cremation 3 □ Removal from State Maryland Nat. Mem. Pk. 2007 4 ☐ Donation 5 ☐ Other (Specify) Laurel, Maryland 22. Name and Address of Facility
Thibadeau Mortuary Service, P.A.
933 Gist Ave., LL, Silver Spring, MD 20910 21. Signature of Funeral Service Licensee Bun milzu M01508 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Non Small Cell Lung Cancer /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Uncertaing Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine or Attending Physiclan: The law requires that the death certificate be executed Due to (or as a consequence of) physician a s the burial-1 Division or Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 🗖 No Year 5 Other (specify) 4☐Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Chronic Obstructive Pulmonary Disease 1 ☐ Yes 2 ☐ No 3 No Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No 24a. Was an has le autopsy performed? /es 22 No page certificate 1□ Yes 26. Place of Death (Check only one) 25. Was case referred to medical Be Other: 4 Nursing Home 5 Anesidence 6 Other (Specify) Hospital 1 ☐ Yes 2X No P 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t Certification: 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide the Hospital 29a. Certifier 1 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier To

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year) SEP 2 5 2007

Abdul Munim, M.D., 8379 Cherry Lane, Laurel, MD 20707

PRICHE

gistrar's Signature

D0055861

September 24, 2007

Please Type or Print in	Black Indelible Ink.	Ensure All Copies	Are Legible

кореп Аргатоміс	1	State of Maryland / Department of He- For State Certificate of De- edistrar		ene Reg. No	2007	3238				
Physician Medical Examine	1	Decedent's Name (First, Middle,Last)  Robert Abramowicz		Date of Death Month Day eptember 29		Time of Death 1400 hrs				
	•	a. Facility Name (if not institution, give street and number)  4b. C	City, Town, or Location of Death		c. County of Death					
Funeral				Date of Birth (M	M/DD/YYYY) 9. Birthp	place (State or Foreign				
Director	L	159-36-7487 1X M 2 F 83 Yrs.	Months Days Hours Min.	u1y 19	, 1924 Coun	Poland				
any	-	Jsual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location			1	0d. Inside City Limits				
Maryland 28a-f show d at once,		MD Cecil Elkton				Yes 2x No				
ith the Maryland 23a or 28a-f sho notified at once.	Director		f. Zip Code	10g. C	itizen of What Countr	y?				
with th			21921 ecedent of Hispanic Origin? (Specify		14. Race - America	n Indian, Black,				
and 2 1215-0036 and 2 should be filed within 72 hours after death with the Maryland feath and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at once	runerar	1 Yes 2 No No	specify Cuban, Mexican, Puerto Rica	an, etc.)	White, etc.	ite				
urs afte	ᇍ	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's U	s 2 X No specify:		Specify: WIN:					
136 thin 72 hours a ne. than "natura edical Examin	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	of working life. DO NOT use retired)							
21215-0036 old be filed within 7 Mental Hygiene. marked other than c event, the Medica	Ę	12 4 Aeron  7. Father's Name (First, Middle, Last)	autical Engine 18.Mother's Name (Fin		Aeronaút:	ıcal				
21215 uld be file Mental Hy marked o	å	Michal Abramowicz	Anna Ko							
D 21 should and Me 7 is ma	≏		dress (Street and Number or Rura							
e, MD 2 I and 2 shou Health and N item 27 is n	ŀ	20a. Method of Disposition 20b. Place of Disposition	11	ate 200	MD 2192 c. Location - City or To					
Pages   Pages   Intt   If		1 Burial 2 **Cremation 3 Removal from State crematory or other page 4 Donation 5 Other Specify: R.A. Ferr	. UCTOD	er 4,	West Ches	ster, PA				
Baltimore, ME permit. Pages I and 2 & Department of Health at Important: Tricen 27 injury or other traums		21. Signature of Funeral Service Licensee 22. Name	e and Address of Facility rew G. Gee Full	neral H	Home					
Physician	+	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the m	ode of dying, such as cardiac or fes	spiratory arlest, s	hock, of heart 2	Approximate Interval Between Onset and				
/Medical Examiner		failure. List only one cause on each line.  Immediate Cause (Final disease a. Hypertensive Atherpsclerotic Cardiova		Death						
		or condition resulting in death)  Due to (or as a consequence of):  b.								
	⊑l	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated								
nd nd nd nd nd nd	Exal	events resulting in death) Last  Due to (or as a consequence of):  d.								
60, ate be exe ohysician a	Medical	UNPENDED AMENDED								
876( tificate ng phy as the b	Ž į	F FEMALE:  3b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy  1 Live birth 2 Fetal d	eath 3 Ectopic pregnancy	I .	23d. Date of delivery  Month Da	y Year				
Box 687  e death certific  the attending p  ed for use as th	Physician	Program at time of death	(Specify)							
O. B at the da lby the tached		Part II. Other significant conditions contributing to death but not resulting in the under	rlying cause given in Part I.	23e. Did tobaco	co use contribute to th	e cause of death?				
D. P. In signed d be de	<u>a</u>	Dementia		1 Yes 2		bly 4 V Unknown				
ord: aw requast been 2 shoul	Completed			24a. Was an autopsy performed	prior to co	psy findings available mpletion of cause of				
Rec : The lificate l		To Was and ordered to reading	26.Place of Death (Check only	1 Yes 2 ✔		2 No				
Vital vsiciam vsiciam vsiciam directo	اقت	25. Was case referred to medical examiner?  1 ✓ Yes 2 No  Hospital: 1 Inpatient 2 ER/Outpatient 3	DOA Other Nursing H		dence 6 🗸 Other:	Scene				
Division of Vital Records, P.O. Italian artending Physician: The law requires that the after after after this certificate has been signed by led in by the funeral director, page 2 should be detact.	의	27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury		d. Describe how i	njury occurred					
Sior Attend r death ector: by the	igi gat	Pending Investigation   28e. Place of Injury - At home, farm, street, fa	1 Yes 2 No	Location (Stree	t and Number or Rura	Route Number City				
Divi	Certification:	Suicide 6 Could not be determined (Specify)	t drig (terribo) or (terre	Trode Names, on						
	29a. Certifier (Check only one) 2 Medical Examiner: On the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29b. Signature and title of certifier (29c. License number 29d. Date signed (Month, Date of Check only one) 29d. Date signed (Month, Date of Check only one) 29d. Date signed (Month, Date of Check only one) 29d. Date signed (Month, Date of Check only one) 29d. Date signed (Month, Date of Check only one) 29d. Date signed (Month, Date of Check only one) 29d. Date signed (Month, Date of Check only one) 29d. Date signed (Month, Date of Check only one) 29d. Date signed (Month, Date of Check only one) 29d. Date o									
To t with To t	Med	and manner stated.  29b. Signature and title of certifier	29c. License number		d. Date signed (Mont					
		Carol Hallen	O.C.M.E.	0	ctober 1, 2007					
4		30. Name and address of person who completed cause of death (Item 23a)  Carol Alian, MD Assistant Medical Examiner 111 Penn Stre	eet, Baltimore, MD 21201			763				
Sta Registr		31. Date filed (Month, Day, Year)  32. Registrar's Signature								
	_									

OCME

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 - State Registrar				C	ertificat	e of	Death		-	Reg. Ne	2007	3	2388
			1. Decedent's Name (First, Mi	ddle, La	st)						2	Date of De	eath Da	ay Yea		Time of Death
	Physici /Medi		Frederick W	illia:	m Alper							Septemb				9:45 a <sub>M</sub>
	Examir		4a. Facility Name (If not institu	tion, give	e street and nun	nber)		4b. City,	Town, o	r Location of				. County of De	ath	
			Suburban Ho	spita	1				Ве	ethesda				Mor	tgome	ry
	Funeral Director		5. Social Security Number 577-52-8469	6. S	ex ⊠M 2□F	7. Age (In yrs.	last birthda Yrs.	Months	Days	If Under 24 Hours	Min.	Date of Bi (Month, Da July 11	rth ay, Year , 194	9. B 1 Dis	Country)	(State or Foreign of Columbi
-	and *		Usual Residence of Decedent 10a. State 10b. Cou	ntv		10c Cit	v. Town or	Location							10d Ir	nside City Limits
	ne Maryla 8a-f sho	Director	Maryland		gomery					otomac					1	☐Yes 2█No
	th with the 23a or 2 ust be no		10e. Street and Number 10714 Potomac	Tenn	is Lane			10f. Zij	o Code	20854			10g. C	tizen of What (	-	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status 1 □ Never Married 2□ N 3 □ Widowed 4 🔼 Divor		12. Was Dece Armed For 1 X Yes If Yes, Giv Year or Da	2 No		3. Was Dece If Yes, spe 1 ☐ Yes		lispanic Origi an, Mexican, Specify:	n? (Speci Puerto Ri	fy Yes or No can, etc.)	0-	14. Race - American Indian, Black, White, etc.  Specify: White		
/ Maryland 21215-0036	72 hour natural dical Ex	Completed t	15. Dece (Specify only hig	dent's Ed	ducation		16a. De	cedent's Usu	al Occup ork done	oation during most o	of working		16b. H	Kind of Busines		
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2	iled v Hygie iher t	ပိ	17. Father's Name (First, Midd	tio I act	2			Denta.	і нуд	ienist	e Namo (	Firet Middle	Maida	Denta n Surname)		
ano	d be antal	Be								ro. mounor		n Hausi		n Garname)		
₹	should nd Me mark matk	٩	Herman A1  19a. Informant's Name/Relati		Type, Print)		19b. Ma	ailing Address	s (Street	and Number				or Town, State	Zin Cod	
_ ≥	od 2 sulth an		Malcolm W. Al				1			ive, Med			-		, L.p 000	"
, ō,	f Hea f Hea ftem other		20a. Method of Disposition	pci	Brother	20b. F	Place of Dis	sposition (Na	me of	- 1	Dat		_	ocation - City	or Town, S	State
Baltimore,	it. Page: rtment o rtant: If njury or		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Pure) at Service 19: 22. Name and Address of Facility										Br	entwood,	Mary1	and
Ba	permi Depar Impor any Ir		21. Signature of Fure all Service Transcer  22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Avenue, Silver Spring, Maryland 2												ıd 20904	
			23a. Part. Enter the disease shock, or hear failure.	, or com List only	plications that ca	aused the deat ach line.	th. Do not	enter the mo	de of dyi	ng, such as ca	ardiac or	respiratory a	arrest,		App Inte	roximate rval Between
	Physician		Immediate Cause (Final disease or condition	nmediate Cause (Final Isease or condition Issulting in death)  A Renal Failure  Due to (or as a consequence of):												
	/Medical		resulting in death)		Due to (	or as a conseq	(uence of):									
	Examiner	Examiner	Sequentially list conditions,		D.	cterial										
B	sit ed		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	₹	Due to (	or as a conseq	uence of):								1	
-	xecut and II-tran	хап	that initiated events resulting in death) Last	1	c	or as a conseq	uence of:									
68760,	ertificate be executed ling physician and e as the burial-transit	ical		l	_d		·									
7/7 P.O. Box 68	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and rail director, page 2 should be detached for use as the burial-transition.	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	5		irth 2∐Feta ant at time of c	al death	3⊟Ectopic p 5⊟Other (s		у			ļ	23d. Date of o	elivery Day	Year
rds, P	w requires that s been signed to should be deta	d by Pl	Part II. Other significant con-	ditions o	contributing to de	eath but not res	ulting in the	e underlying (	cause giv	ren in Part I.				use contribute		use of death? 4 ⊠Unknown
ر Division or Vital Records,	The law recte has bee age 2 shou	Completed										24a. Was	opsy formed?	l death	?	indings available tion of cause of
ita	sician: Th certificate rector, pag	Be C	25. Was case referred to med	lical						26. Place of	of Death (	1□ Yes Check only		0 1 111	es 2 🗌	INO .
>	nysic lis ce direc	To B	examiner? 1 ☐ Yes 2 ☑ No		Hospital: 1区I	npatient 2	ER/Outpat	tient 3 □ D	OA Oth	OF:		1997		6 □Other (S)	ecify)	
o uoisivi	Ilng Afte fune		27. Manner of Death 1 ☑ Natural 5 ☐ Per 2 ☐ Accident	nding estigation		of Injury h, Day Year)	28b. Time Injur	e of y M	28c. Inju Wor 1 □	ryat rk?  Yes 2 □ Ne		d. Describe	how inju	ury occurred		
) Sivid	To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Certification:		uld not be ermined	Zee. Place	of injury - At h	ome, farm,	street, factor	y, office		28	f. Location City or To	(Street a own, Sta	and Number or te)	Rural Rot	rte Number,
	ne Hosplin 24 hour ne Funera	Medical (	29a. Certifier 1 ★ Certi (Check only 2 ★ Medi	fying Ph cal Exar	nysician: To the miner: On the ba and manr	asis of examina	owledge, de ation and/or	eath occurred r investigatio	d at the ti n, in my	me, date and opinion, death	place, ar	d due to the	e cause( e, date a	s) and manner nd place, and d	as stated ue to the	cause(s)
	To the Within To the Complex c	ž	29b. Signature and title of cer	tifier	0 _			29	c. Licens	se number			29d. D	ate signed (Mo	nth, Day,	Year)
	7		) qu			10	2		D37	891			S	September	18,	2007
	~		30. Name and address of per Amit Kumar Rajv						, Sui	te 409,	Rocky	ville,	Mary1	and 2085	2	
	Sta	ate	31. Date filed (Month, Day, Ye	ear)	32 R	egistrar's Signa	ature									
	Regist		SEP 2	4 20	N7 /		H A	hack 8								

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and Division or Vital Records, P.O. Box 68760, filled in by

altimore, Maryland 21215-0036

🛮 🕜 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d, Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ave Brunswick 610 Kathleen

State Registrar 31. Date filed (Month, Day, Year) SEP 2 5

2007

32. Registrar's Signature

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** OCTOBER 2007 15:20 Boch Berl /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MEMORIAL HOSPITAL CUMBERLAND ALLEGANY If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Feb 13, 1935 6. Sex Birthplace (State or Foreign Country). **Funeral** 1 □ M 2 □ F "%/\/ Director 218-30-0464 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10a, State 10c. City, Town or Location 10d, Inside City Limits Cumberland MD Allegany Y⊟Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21502 USA 220 Somerville Ave. Apt. 31 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No <u>م</u> Specify: white 3√ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) homemaker own home 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Rosa Rohrbaugh Van Meter George C. VanMeter ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

14110 Upper Sunnyside Mt. Savage MD 21545 Rosa Twigg daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 10/8/2007 Davis Memorial Cemetery Cumberland MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Scarpelli Funeral Home, PA 23a. P. 11. Enter the disease, or complication, that caused the disease or condition.

Immediate Cause (Final disease or condition resulting in death)

Immediate Cause (Final disease or condition resulting in death) 108 Virginia Avenue: Cumberland, MD 21502 Approximate Interval Between Onset and Death **Physician** 2 YEARS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Dusito (or as a consequence of: burial-trar Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🛣 No Month 4□Pregnant at time of death Day Year 5 Other (specify) sate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autoosy performe 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ■Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No 2 ER/Outpatient 3 DOA မှ 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred (Month, Day Year) 1 X Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D14865 30. Name and address of person who completed cause of death (Item 234) (Type, Print) 4 500 MEMORIAL AVENUE, SUITE 201, CUMBERLAND, MD 21502 ROBUSTIANO M.D., BARRERA 31. Date filed (Month, Day, Year) Registrar's Signature State OCT 1 0 2007 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

**Physician** /Medical Examiner

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attending physician for use as the buria

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After or Attending

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Hospital

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Completed

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Certification:

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The law requires that the death certificate be executed

Physician:

Division or Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any injury or other trai once.

**Physician** 

/Medical

Examiner

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Funeral

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Completed

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**Funeral** 

Director

r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
nt: If Item 27 is marked other than "natural;" or items 23a or 28a-f show

Baltimore, Maryland 21215-0036

Examiner Physician/Medical

25. Was case referred to medical examiner? 2 No 1 ☐ Yes 27. Manner of Death

5 ☐ Pending investigation 6 ☐ Could not be

Hospital: 1 Inpatient 2 ☐ ER/Outpatient 28a. Date of Injury (Month, Day Year) 28b. Time of Injury

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 3□ DOA 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

29a. Certifier

1 Natural 2 ☐ Accident

3 ☐ Suicide

4 Homicide

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number D0012015

29d. Date signed (Month, Day, Year) GY92 Landover Rd D GY92 Landover Landover

E. 31. Date filed (Month, Day,

Year) 2007

Steinberg: M.D 32. Registrar's Signature

Registrar DHMH 17 Rev 1/2001

State

and address of person who completed cause of death (Item 23a) (Type, Print)

Division or Vital Records, P.O. Box 68760,

within 24 hours after death.

To the Funeral Director: / the

> State Registrar

Medical

Margaret Akpan, M.D. 31. Date filed (Month, Day, Year) SEP 2 5 2007

29a. Certifier

(Check only one)

29b. Signature and title of certifie

3001 Hospital Drive Cheverly, Maryland 20785 32. Registrar's Signature A.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29c. License number

D31528

29d. Date signed (Month, Day, Year)

September 20, 2007

State of Maryland / Department of Health and Mental Hygiene 32393 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** 19, 2007 3:38 а м Annie Sept. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Fort Washington Hospital Fort Washington Prince Georges If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. Date of Birth (Month, Day, Year) Nov. 4, 1 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2√2 F 577-22-6826 Yrs. 86 1920 Virginia Director Usual Residence of Decedent deeth with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits • how item 27 is marked other then "naturel", or Items 23a or 28s-f ehos other traumatic event, the Medical Examinar must be notified at DC Washington X Yes 2 No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 930 Farragut Street, N. W. 20011 U. S. A. Funerai 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. Black e filed within 72 hours after all Hygiene. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 🎾 No Specify Completed by Specify 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) N. I. H. 8th Dietician 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Peges 1 and 2 should be fill iment of Heelth and Mental Hitem 27 is marked out Be Bernard Ford, Sr. Elizabeth Bentley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 523 Wilson Bridge Drive #A2Washington, Md. 20744 Marilyn A. Conerly (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3 □ Removal from State permit. Pege Department importent: If eny injury o 09/27/07 Fort Lincoln Cemetery Brentwood, Md. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
W. H. Bacon Funeral Home, Inc.
3447 14th Street, N.W. Washington, D.C. 21. Signature of Funeral Service License 36 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the peath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition **Physician** /Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner death certificate be executed use as the burial-transit that initiated events resulting in death) Last and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. attending physicien for use as the buria Physician/Medicai IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day Year Month 4☐Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by should be 1 🗌 Yes 2 X No 3 Probably 4 Unknown been 24b. Were autopsy findings available prior to completion of cause of death? 77\_\_\_\_ 24a. Was an page 2 autopsy performed? certificate 1 ☐ Yes 🐰 ☐ No 1 ☐ Yes 2 No filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes No ٩ 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Injury he Hospital or Attending P. n 24 hours after death. he Funerel Director: After ti 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification; 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of fnjury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Momicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier Medicai and manner stated. within 2 the e 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2 46046 9-18-2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

14.1 11/1/18/14. 11911 [LUNGS TON Rd. Ft. Washington, Md. 20747 32. Registrar's 31. Date filed (Month, Day, Year) State 2007 2 5 Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygier 0071- State Registrar Amend#'s 20b.c. PerFHPCC9-28-07cr Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2007 Month **Physician** Katie 23, В. Sept. Brooks 11:10p M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Fox Chase Nursing & Rehab. Ctr. Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** 1 ☐ M 2 🖫 F 242-10-5769 Yrs. North Carolina Director Nov. 11, 1909 Usual Residence of Decedent with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "naturel", or items 23s or 28s-f show the Medical Exeminer must be notified at 1∏Yes 2∏No Director D. C. Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 601 "L" Street, S. E. 20003 U. S. A. death 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be tiled within 72 hours after Department of Health and Mental Hygiene. I lend protent: if item 27 is marked other than "naturel", or iter any injury or other treumatic event, the Madical Exemples once. 1 ☐ Yes 2 📉 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Black Specify: þ 3 ☑ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Factory Worker Factory 6th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Sam Green Ella Whitfield 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5000 13th Street, N.E. Washington, DC 20017 Illma Best (Friend) 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition Maryland Washington National 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Suitland Laurel, 09/29/07 21. Signature of Funeral Service Licensee 22. Name and Address of Facility W. H. Bacon Funeral Home, Inc. 3447 14th Street, N. W. Washington, D.C. 20010 0361 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Priysician Chronic Renal Insufficiency, DM, HTN, /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Arteriolosclerotic Heart Disease, Vascular Dementia Due to (or as a consequence of) Examine law requires that the death certificate be executed burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant ed by the atter 3 Ectopic pregnancy in the past 12 months?
1 Yes 2X No Year Month Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown been signed by t should be detach Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Diabetes Mellitus, Hypertension, Anemia Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas autopsy performed? this certificate 1 Yes 2℃ No 1 ☐ Yes 21 No al or Attending Physicien: 1 s after death. el Director: After this certifical ed in by the funeral director, p 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 10 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 3 🗌 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide To the Hospital o within 24 hours aft To the Funerel Di 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie Sept. 24, 2007 D0064578 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8609 Second Ave., Suite 404B Mehmooda Naeem, M. D. Silver Spring, Md. 20910 32. Registrar's Signature 31. Date filed (Month, Day, Year) State SEP 2 5 2007 red) Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygien 2007 32395

	•	State Registrar		Certificate	of Death	Re	eg. No.	02000
Dhariai		1. Decedent's Name (First, Middle, Last)				2. Date of Deat		3. Time of Death
Physicia /Medic			S. BROWN			SEPT.	1 <sup>9</sup> , 2ď07	2117 м
Examin	er	4a. Facility Name (If not institution, give since Shady Grove Adv			own, or Location of Death Rockvill		4c. County of Death	
Funeral Director		5. Social Security Number 218-20-2118 6. Sex 1 ₩ Usual Residence of Decedent	7. Age (In yrs. I	ast birthday) If Under 1 Yrs. Months	Year If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day, May 25	9. Birth Cou. 5, 1925 M.	place (State or Foreign intry) aryland
land ow at		10a. State 10b. County	10c. City	, Town or Location				10d. Inside City Limits
Many a-f sh	tor	MD Montgo	mery	Germant	own			1 XYes 2 No
th the or 28s e not	Director	10e. Street and Number	Į.	10f. Zip C		10	0g. Citizen of What Cou	intry?
ath wi 23a ust b	ral	19304 Circle G	· · · · · · · · · · · · · · · · · · ·		20874		U.S.A.	
er de:	Funeral [		Was Decedent Ever in U.     Armed Forces?	S. 13. Was Decede If Yes, specif	ent of Hispanic Origin? (S fy Cuban, Mexican, Puerl	pecify Yes or No- to Rican, etc.)	14. Race - Ameri Black, White	
hours after death with the Maryland tural", or Items 23a or 28a-f show al Examiner must be notified at	by F	1 ☐ Never Married 2 Married 3 ☐ Widowed 4 ☐ Divorced	1 XYes 2 No If Yes, Give Year or Dates: 45 -	•46 1□Yes 2	No Specify:		Specify: B	lack
be filed within 72 hours after death with the Marylan tal Hygiene. tal Hygiene. d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at		15. Decedent's Educ (Specify only highest grade	ation	16a. Decedent's Usual	Occupation	ting	16b. Kind of Business/I	ndustry
be filed within 72 tal Hygiene. d other than "nai event, <u>the Medic</u>	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		done during most of wor retired)	KIIIG	MD State	
led w lygier her th		10 th  17. Father's Name (First, Middle, Last)		Super		ne (First, Middle, M	Administ	ration
d be fi	Be C	William E. Br	OWn				Jenkins	
should nd Me mark imatt	은	19a. Informant's Name/Relationship (Typ		19b. Mailing Address (	Street and Number or Ru			p CodeD \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \
and 2 alth a 27 is		Catherine Brow	n (Wife)		rcle Gate			
of He of He fitem		20a. Method of Disposition 1 ☑ Buila 2 ☐ Cremation 3 ☐ Re	20b. P	lace of Disposition (Name emetery, crematory or oth	e of ner place)	Date	20c. Location - City or T	own, State
Pag Iment Iant: I		4 ☐ Onation 5 ☐ Other (Specify)	1 Jo	hn Wesley			Clarksbur	w 1
permit. Pages 19 Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, the Monte.		21. Signature of Funeral Service License	nouden		Address of Facility SI . Washingt			
N 4185		3a. Part1. Enter the disc se, or complice shock, or heart failure. List only on	cations that caused the date e cause on each line.	n. Do not enter the mode	of dying, such as cardia	or respiratory arre	est,	Approximate Interval Between
Physician		Immediate Cause (Final disease or condition	Cardio	enic Shoc	k			Onset and Death
/Medical Examiner		resulting in death)	Due to (or as a consequ	uence of):				
a a	-	Sequentially list conditions, if any leading to immediate	Severe  Due to (or es a consequ	Cardiomyo	pathy		-	
uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		ge Renal	Disease			
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atter for u	Physician/Me	in the past 12 months?	3c. If yes, outcome pf pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d 9 □ Unknown	I death 3 □Ectopic pre	gnancy cify)		23d. Date of deliver Month	very Day Year
that the de ned by the a	Phy	9 ☐ Unknown  Part II. Other significant conditions con		ulting in the underlying car	use diven in Part I	23e Did tob	pacco use contribute to	the cause of death?
signe d be c	d by	Takin Guidi digililidan Gerianen Geri	and any to down but not root	and the underlying out	acc given in rait i.		es 2 No 3 Pro	
w requir been si should	Completed					24a. Was a		topsy findings available
The lay	duic					autops perforr	v prior to c	ompletion of cause of
	Be C	25. Was case referred to medical			26. Place of Dea	1 Yes 2 ath (Check only on		2 No
hysici this ce al direc	To B	examiner? 1 ☐ Yes 2XNo	ospital: 1 【Anpatient 2 □	ER/Outpatient 3 ☐ DOA	Other:		ence 6 Other (Spec	ify)
ding Pt h. After th funeral	* *	27. Manner of Death  **XNatural 5 □ Pending	28a. Date of Injury (Month, Day Year)		c. Injury at Work?	28d. Describe ho	ow injury occurred	
Attending Physician: r death. ector: After this certific by the funeral director,	cati	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of injury - At ho	M M	1 Yes 2 No	206 Lanation (Ct	and and Number of Di	n I Davida Alivertan
al or A s after al Direct	Certification	4 Homicide determined	building, etc. (Specify	y)	onice	City or Town	reet and Number or Ru n, State)	ar noute Number,
To the Hospital or Attend within 24 hours after death To the Funeral Director; completely filled in by the f	Medical (	29a. Certifier (Check only one) 1 Certifying Phys 2 Medical Examin	ician: To the best of my kno ler: On the basis of examina and manner stated.	wledge, death occurred a tion and/or investigation,	t the time, date and place in my opinion, death occ	e, and due to the courred at the time, d	ause(s) and manner as late and place, and due	stated. to the cause(s)
To the within To the comp	Me	29b. Signature and title of certifier	11.0.1	290.	License number	2	9d. Date signed (Month	, Day, Year)
10		* autender /	. / Villamino	מויו	D006581	9	9/19/0	7
, -		30. Name and address of person who con Alexander K. M.			dical Cen	ter Dr,	Rockvill	e,MD 20850

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year) SEP 2 5 2007

32 gegištrar's Signeture

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) SEPT. 19, 2007 4:45 PM **Physician** BOWIE GEORGE Ε. /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner MONTGOMERY Olney Montgomery General Hospital 8. Date of Birth (Month, Day, Year) Tully 28,1953 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Funeral Months Days Hours Min. Maryland 1 X M 2 □ F 54 Director 215-66-7926 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State show ?7 is marked other than "natural", or Items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at 1 TXYes 2 □ No Wheaton Director MD Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20852 U.S.A. 12036 Valleywood Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black, White, etc. 72 hours after 1 ☐ Mever Married 2 ☐ Married Black Maryland 21215-0036 1 ☐ Yes 2 No Specify: 2 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filled wi Department of Health and Mental Hygien. Important: If item 27 is marked other the any Injury or other transment. FEMA Custodian 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Martha Thomas John A. Bowie 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 12036 Valleywood Dr, Wheaton, MD 20902 (Sister) Eleanor L. Ware 3altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 9/24/07 Riverdale, MD 4 □ Donation 5 □ Other (Specify) werdale Pk Cre 21 Ignature of Funeral Service 22. Name and Address of Facility SNOWDEN FUNERAL HOME, P.A. 10 246 N. Washington St, Rockville, MD 20850 23a. Part1. Enter the disease, or comblications that shock, or hear failure. List only one cause in Immediate Cause (Final disease or condition resulting in death) cau ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner The law requires that the death certificate be executed that initiated events resulting in death) Last burial-trar Due to (of as a conseq attending physician for use as the buria Division or Vital Records, P.O. Box 68760 Physician/Medical 23d. Date of delivery 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? director, 26. Place of Death Check onl one Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Inpatient 1 Yes 2 No 2 ER/Outpatient 3 DOA Certification: To this 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred After t Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No М 24 hours after death • Funeral Director: 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical To the Fune 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To th. within 2 To the Fu 29c. License nµmber 29d. Date signed (Month, Day, Near) 29b. Signature and title of person who completed cause of death (Item 23a) (Type, Print) 30. Name and add 120 Registrar's Signature 31. Date filed (Month, Day, Year) State 25 SEP Registrar

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036 Division or Vital Records, P.O. Box 68760,

		1 - For State Registrar	State of Ma	-	ertificate of D		ental Hygie Reg	2007	32397	
Physici		Decedent's Name (First, Middle, Last)  EARL  B			BAKER	2. Date of De Month			3. Time of Death	
/Medic		4a. Facility Name (If not institution, give street and number)			4b. City, Town, or I	ocation of Death		12 2007 4c. County of Dear		
		WMHS-BRADDOCK CAMPUS			CUMBERLA			ALLEGANY		
Funeral Director		219-34-0323	ex 7. Age	85 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, Y June 29	(ear) Co	thplace (State or Foreign buntry) Maryland	
land ow at		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City Limits	
e Man ta-f sh tified	ctor	Maryland A	llegany			Cumberland			1 □Yes 2 🛣 No	
with th	Director	10e. Street and Number	D: 4	5.4	10f. Zip Code	01.700	10g	. Citizen of What Co		
ns 23	Funeral	11. Marital Status	Drive Apartme		. Was Decedent of His If Yes, specify Cuban	21502 panic Origin? (Spe	ecify Yes or No-	14. Race - Ame		
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at ance.	þ	1 (Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:	10	If Yes, specify Cuban  1 ☐ Yes 2 😿 No	Specify:	Rican, etc.)	Black, Whit	e, etc. White	
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within iene. than '	Completed	Elementary/Secondary (0-12)	College (1-4or 5	+) life.		ver Worked		Neve	er Worked	
e filed al Hyg l other vent, i	Be	17. Father's Name (First, Middle, Last)		· · · · · · · · · · · · · · · · · · ·		18. Mother's Name (First, Middle, Maiden Surname)				
Menta arked aric evaluation			Leo Lee Bak					y Doffellmar		
d 2 sho		19a. Informant's Name/Relationship (Type. Print)  Carol Cutter-Wolz - Executive Director			Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 54 Jackson Street, Lonaconing, Maryland, 21539					
tges 1 and of Heal		20a. Method of Disposition 1 🕱 Burial 2 □ Cremation 3 □		osition (Name of Particular of Particular of October 05, Date October 05,			Town, State			
nit. Pa artmer ortant: injury		4 □ Donation 5 □ Other (Specifical Signature of Funeral Service Licer	ISAC.		k Hill Cemeter  22. Name and Address		2007		ng, Maryland	
Dep Imp any		for & M	Rene					coning, MD 2		
1213		23a. Part1. Enter the disease, or complication. In at caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or leart failure. List only one cause on each line.  Approximate Interval Betwee Onset and Dea								
Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Aca	te myo	cardial i	nterchou	^		3 Ray	
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D #5	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Uniterlying Cause (Disease or injury	Due to (or as	a consequence of):						
execute and al-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last c								
icate be executed physician and s the burial-transit	edical E		<b>_</b> d							
ertifica ling ph e as th		IF FEMALE:	00:16							
The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the bunal-transit	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death 3	□Ectopic pregnancy □ Other (specify)			23d. Date of de Month	livery Day Year	
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w require been signature		Atoute Ken	el tailur	<u> </u>			1 ☐ Yes	2 <b>\</b> No 3□P	robably 4 □Unknown	
rsician: The law s certificate has b lirector, page 2 sh	Completed	Resolvatory	Failure	hy			24a. Was an autopsy performe 1□ Yes 2	prior to	utopsy findings available completion of cause of 2 No	
iclan; certific ector,	Be	25. Was case referred to medical examiner?	Hospital:		Out.		(Check only one)			
Phys	- L	1 ☐ Yes 2 No 27. Manner of Death	28a. Date of Inju	nt 2 ER/Outpatie	SIII SLI DOA	4 Linursing Ho	me 5 Residen	ce 6 Other (Spe	ecify)	
nding ath. r: Afte e fune	ation	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day			es 2□No		,,		
ii or Atte after dea i Directo	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of injubuilding, etc	ury - At home, farm, s c. (Specify)	street, factory, office		28f. Location (Stre City or Town,	et and Number or R State)	ural Route Number,	
To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certifica completely filled in by the funeral director.	Medical C			examination and/or	ath occurred at the timing investigation, in my op					
29b. Signature and title of certifier  29c. License number				290	I. Date signed (Mon.					
	2	30. Nime and address of person who	completed cause of de	. 4.0	a colo	n N-	Cambert		21572	
Sta Registi	ate	31. Date filed (Month, Day, Year)		ar's Signature	Araello		www.ser(	WAY 1.0	7.302	
3			1000	ALL ALL ALL ALL ALL ALL ALL ALL ALL ALL						

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death September 19 2007 **Physician** Michael E. Barr /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 1623 Hilltop Road Edgewater Anne Arundel If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 1X M 2 ☐ F Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Director 230-76-6008 56 04/25/1951 Virginia Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10b. County 'natural', or items 23a or 28a-f show dical Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Anne Arundel Edgewater 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code United States 1623 Hillton Road 21037 death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race · American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after inent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or iter 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: þ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 72 ht Department of Health and Mental Hygiene. important: If item 27 is marked other than "natuany injury or other traumatic event, the Medical. 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Logistics Specialist U.S. Air Force 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Jessie Noah Barr Anna May Blevins 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia M. Barr/Wife 1623 Hilltop Road, Edgewater, Maryland 21037 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Kalas Crematory 09/20/2007 Edgewater, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility George P. Kalas Funeral Home 21. Signature of Funeral St 2973 Solomons Island Rd., Edgewater, MD 21037 4 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Approximate Interval Between Onset and Death Fuilur **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner requires that the death certificate be executed (u- lin oma and burial-tran Due to (or as a consequence of): Box 68760, physician Physician/Medical the as t attending IF FEMALE: asn 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy į in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) P.0. the detached 9□Unknown 9 Unknown þ signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, ģ 1 🗌 Yes 2 No 3 Probably 4 Unknown cate has been si page 2 should l Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed certificate 1□ Yes 2 NO funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tyes 1 ☐ Inpatient 2 ER/Outpatient 3 DOA P After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: To the Hospital or Attending 5 ☐ Pending investigation Injury 1 □ Yes 2 □ No Il Director: A death 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide determined after within 24 hours a To the Funeral C 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature an son who completed cause of death (Item 23a) (Type, Print) de nartin ላዲሳ 22 S. Greene Street, Baltimore, Maryland 21201 31. Date filed (Month, Day, Year) State SEP 2 4 2007 Registrar

			1 = For State Registrar	State of Ma	arylan			nt of He te of D		Mental Hy	/gien Reg. No	0007	22200
	Physici	an	1. Decedent's Name (First, Middle, La	*						2. Date of D	eath	<u> </u>	3. Time of Death
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1	Examin	er	Anne Arundel Med					apoli:		aur		ne Arun	
	Funeral		5. Social Security Number 6. 578-42-5696	Sex 7. Age	e (In yrs. I 72	ast birthday) Yrs.	If Unde Months		If Under 24 Hi Hours Min		rth	9. Birt	hplace (State or Foreign untry) hington, DC
	Director		Usual Residence of Decedent							00/0//	193	was	
	larylan show ed at	J.	10a. State 10b. County	4 . 1		, Town or Lo							10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	r 28a-f	Director	Maryland Anne Art  10e. Street and Number	inger	rag	ewater		o Code			10g. C	itizen of What Co	untry?
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36	d within 72 hours after death with the Maryland giene. r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 ★ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Armed Forces?  1 Yes 2 X If Yes, Give Year or Dates:	Ever in U.: No	S. 13. \	Was Dece f Yes, spe 1 ☐ Yes		panic Origin? , Mexican, Pue Specify:	(Specify Yes or N erto Rican, etc.)	0-	14. Race - Ame Black, Whit Specify: Wh	
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nd 2	e file al Hy othe vent,	Be C	17. Father's Name (First, Middle, Las	r)		2020		1		ame (First, Middle	e, Maide		
Maryland	should be ind Mental i marked o i maric eve	2	Louis Blume  19a. Informant's Name/Relationship	(Time Print)		10h Mailin	a Addros			elia Hurv		as Taura Ctata	Zin Ondal
Ma	nd 2 saith ar 27 is r trau		V. Pauline Blume				-			ater, Ma			
ore,			20a. Method of Disposition 1 ☐ Burial 2 🛣 Cremation 3 [		20b. P	lace of Dispo emetery, crer	sition (Na	me of other place		Date		ocation - City or	
Baltimore,	구두유국		4 □ Donation 5 □ Other (Special Signature of Fundamental Property)	fy)	Ka1	as Cre			of FacilityC -	23/2007	Edg	ewater.	Maryland
Ba	permi Depai impoi any ir		1 Men	a	-					eorge P.			
1			23a. Part1. Enter the disease, or con shock, or heart failure. List only	plications that caused one cause on each lir	ne.			de of dying	, such as cardi	iac or respiratory	arrest,		Approximate Interval Between Onset and Death
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68760,	icate be executed physician and s the burial-transit	edical		d									
P.O. Box 6	death certif e attending d for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1□Live birth 4□Pregnant at 9□Unknown	2 Fetal	death 3	]Ectopicp ]Other (s				J	23d. Date of de Month	ivery Day Year
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or Vital Records,	The law ate has b	Completed	coronony	orte-	7	elis.	e 0 5 1	c		24a. Was - auto pert 1∐ Yes	s an opsy ormed? 2 X N	prior to death?	utopsy findings available completion of cause of 2 □ No
Vita	sician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:				Othor		eath (Check only			
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	Hospi 24 hours Funer etely fill	Medical	29a. Certifier (Check only one) 1 Sectifying P	hysician: To the best of miner: On the basis of and mapper sta	examinat	wledge, death tion and/or in	n occurred vestigation	at the time n, in my opi	e, date and pla inion, death oc	ice, and due to the courred at the time	e cause( e, date ar	s) and manner as nd place, and due	s stated. e to the cause(s)
	To the within To the Comp	Me	29b. Signature aportitle of certifier	0 //-			1	c. License				ate signed (Mont	
	Sold,	6	P VY / C	letter	and the	02a) (T	Dain 45	1)2	1800	1	7	1-22-	-2007
	10.120		30. Name and address of person who	terson	14	D	rint) A	An	1	Ann	chel	les MI	21401
	Sta Registr	_	31. Date filed (Month, Day, Year) SEP 2 4	32. P gistra	ar's Signal	ture	ford	2					

07-07392					
Linda Brockley					

	State of Maryland / I	Department of F Certificate of D			. No. 200	7 3240
Physician/	Decedent's Name (First, Middle,Last)			2. Date of Death		3. Time of Death
Medical Examiner	Linda Christofano Brockley  4a. Facility Name (if not institution, give street and number)	Tab	City, Town, or Location of Deatl	Month September	21, 2007 4c. County of Death	1954 hrs
Jkg stern	Dorchester General Hospital		Cambridge	4.527	Dorchester	
* Funeral	5. Social Security Number 6. Sex 7. Age (	In yrs. last birthday)	f Under 1 Year If Under 24Hrs	8. Date of Birth	(MM/DD/YYYY) 9. Biri	
Director	222-34-5422 1_M 2_XF 49	Yrs.	Months Days Hours Mir	Aug 29	1958 Foreig	untry) NJ
	Usual Residence of Decedent	2-01-7	· · · · · · · · · · · · · · · · · · ·			10d. Inside City Limits
ow any	MD Dorchester	Cambridge				1 X Yes 2 No
Aaryland 28a-f show <u>1 at once,</u> ector	10e. Street and Number		Of. Zip Code	100	g. Citizen of What Cour	*
imore, MD 21215-0036  Pages I and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.  The marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once.  To Be Completed by Funeral Director	200 Maryland Avenue		21613		nited State	
ms 23: be not	11. Marital Status 12. Was Decedent Evaluation of the Status Armed Forces?		ecedent of Hispanic Origin? (S		14. Race - Ameri White, etc.	can Indian, Black,
r death with or items 23 must be no Funeral	1 Yes 2X	No	es 2 No specify:	r riodii, Oto.	lal h	ite
rs afte	Widowed 4 Divorced If Yes, Give Year or Dates:  15. Decedent's Education (Specify only highest grade complete.		Usual Occupation (Give kind of	work done	Specify: MIT 16b. Kind of Business/	
5-0036 ed within 72 hour 19 yigiene. other than "natu the Medical Exar Completed	Elementary/Secondary (0-12) College (1-4 or 5+	during most	of working life. DO NOT use re-			
1036 vithin ene. er thau redic	4	Homem			Own Home	9
ID 21215-0036 should be filed within 7 and Mental Hygiene. 7 is marked other than natic event, the Medica To Be Comple	17. Father's Name (First, Middle, Last) Emil Christofano		18.Mother's Nam	e (First, Middle, M Zschimme	aiden Surname) <b>°</b>	
2121; hould be fil and Mental I: is marked tric event, I	19a. Informant's Name/Relationship (Type, Print )	19b. Mailing A	ddress (Street and Number or	Rural Route Numb	per, City or Town, State	, Zip Code)
MD  1d 2 sho  1d 2 sho  1d 1th and  1m 27 is  2 aumati	Richard Brockley (husba	nd)   200 Mar	yland Ave., Ca	mbridge,	MD 21613	
ore, ME	20a. Method of Disposition  1 Burial 2 X Cremation 3 Removal from State	20b. Place of Disposition crematory or other		Date	20c. Location - City or	Town, State
Baltimore, Permit. Pages I ar Department of Hee Important: If ite njury or other ir	4 Donation 5 Other Specify:	Hockessin		/25/07	Hockessin	
Baltimore, MI pernit. Pages I and 2 s Department of Health a Important: If item 27 injury or other traum.	21. Signature of Funeral Service Licensee		ne and Address of Facility		r Funeral I	
Physician	23. P.f. I. Enter the disease, or complications that caused th	e death. Do not enter the	Concord Pike, mode of dying, such as cardiac	or respiratory arre	st, shock, or heart	Approximate Interval
/Medical	foliure. List only one cause on each line.  Imprediate Cause (Final disease a. Occlusive Pulmor	nary Thromboembo	ism			Between Onset and Death
≒xaminer	or condition resulting in death)  Due to (or as a consequence)	·		- P		
e e	Sequentially list conditions, if any, leading to immediate  b. lower extremity of Due to (or as a consequence)	eep vein thrombosis				
ted Insit Examine	cause. Enter Underlying Cause (Disease or Injury that initiated					
d ansit	events resulting in death) Last  Due to (or as a consequence of the co	uence or):				
Vital Records, P.O. Box 68760, spician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and director, page 2 should be detached for use as the burial - transit o Be Completed by Physician/Medical Ex	UNPENDED AMENDED	-				
760, icate be physici the buri	IF FEMALE: 23c. If yes, outcome 23b. Was decedent pregnant in the		• <b>-</b>		23d. Date of deliver	
Box 6876 The death certificate the attending physical for use as the thysician/M	past 12 months?  1 Live birth 4 Pregnant at tir		death 3Ectopic pregr (Specify)	iancy	Month	Day Year
D. Boy the death by the att	1 Yes 2 No 9 V Unknown 9 Unknown					
P.O. s that the greed by e detach	Part II. Other significant conditions contributing to death be	out not resulting in the und	erlying cause given in Part I.		pacco use contribute to	
ts, F quires en sign uld be				24a. Was a		utopsy findings available
Records, I The law requires fricate has been sig				autops	sy prior to	completion of cause of
Rec The fificate r, page			26 Diago of Dooth /Chaol	1 Yes 2	2 No 1 🗸 Y	es 2 No
Vital ysician ysician his certi directo	25. Was case referred to medical examiner?  Hospital: 1 Inpatient	2 Z ER/Outpatient	26.Place of Death (Check Other's Nurs		Residence 6 Othe	r:
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the rs after death.  The Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach ertification: To Be Completed by P	1 Yes 2 No  27. Manner of Death 28a. Date of Injury (Month, Day, Yea			28d. Describe h	ow injury occurred	
ion tendir tor: A the fu	1 Natural 5 Pending 2 Accident Investigation	.,	1 Yes 2 No			
Division o spital or Attending nours after death. filled in by the func Certification:	3 Suicide 6 Could not be 28e. Place of Inju	ry - At home, farm, street,	factory, office building, etc.	28f. Location (S or Town, St		ural Route Number, City
ospita hours hours ly fille	29a. Certifier	- death assures	d at the time date and alone on	d due to the equal	a(a) and manner as sta	lod.
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Fineral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi Medical Certification: To Be Completed by Physician/Medical Ei	one) 2 ✓ Medical Examiner:On the basis of exami	-				
To To	29b. Signature and title of certifier		29c. License number		29d. Date signed (Mo	onth, Day, Year)
	my hu, mp		O.C.M.E.		September 22, 2	2007
10	30. Name and address of person who completed cause of dea		Baltimore, MD 21201			
√D State	Ling Li, MD Assistant Medical Examiner  31. Date filed (Month, Day, Year) 32, Registrar's	Signature				
Registrar	SED 2 5 2007 Manual	H speed		_		

DHMH 17 Rev 1/2001 OCME 2006

OCME

ORIGINAL

Physician /Medical Examiner Physician/Medical Examiner

**Physician** 

/Medical

Examiner

**Funeral** 

Director

or items 23a or 28a-f show iminer must be notified at

traumatic event, the Medical Examiner

Maryland 2121

Baltimore,

Pages 1 nent of H Department of Important: If it any injury or conce. Director

Funeral

Completed by

Be

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burial-trar physician s been signer should be or page 2 this

death certificate be executed or Attending 24 hours after death. Funeral Director: / filled in by

Be Completed by

Certification: To

Medical

Division or Vital Records, P.O. Box 68760,

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 3□ DOA 2 ER/Outpatient Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 Pending investigation 1 Yes 2 No 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 26064

09-23-2007

10583-THEODORE GREEN BLD WHITE PLAINS, MD - 20695

Registrar

completely

within a

DHMH 17 Rev 1/2001

NMANGANDLA

MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

VIDYASAGAR

State of Maryland / Department of Health and Mental Hygiene, Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month Vear Mary Myrtle BUSSARD September 27 2007 5:17aм /Medical 4a. Fecility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Charlotte's Home Maugansville Washington If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 257 F 220-26-7334 81 Director Oct. 26, 1925 South Carolina Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits J Hygiene. other then "neture!", or Items 23a or 28e-f ehow vent, the Medical Extending Crisist be notified at 1 ☐ Yes 2 No Director Maryland Washington Maugansville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13715 Village Mill Drive 21767 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black. White, etc. within 72 hours after 1 ∐Yes 2 [X]No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: white Specify: à 3 ™ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) unknown unknown seamstress clothing mfg. permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If Item 27 1e marked othe eny Injury or other treumatic event, once. 17 Father's Name (First Middle Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Willie A. Robison Ida Williams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Steve L. Bussard - son 13427 Greencastle Pike, Hagerstown, Md. 21740 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Rest Haven Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 9/29/07 Hagerstown, Maryland 21. Signature of Funeral Service 22. Name and Address of Facility MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 23a. Part1. Enter the disease, or comshock, or heart failure. List only or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ist only one cause on each line. Approximate Interval Betw Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician amplication au /Medical Due to ( r as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine physicien and the burial-transit death certificate be executed Due to (or as a consequence of) Box 68760. Physician/Medicai USB as IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ğ in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the e P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ of Vital Records, The law requires Hypritani 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Denknown After this certificate has been si funeral director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ို Yes 2 No rpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: Division 1 Natural 5 Pending death. 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 405 1 Yes 20 No ours after death.
nerel Director: A investigation **Accident** 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 ☐ Homicide ō To the Hospital
within 24 hours a
To the Funerel L Home 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

25 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 00056965 DIME 30. Name/and address o address of person who completed cause of death (Item 23a) (Type, Print) 54 real Hyort - MO 2174 44-2 251 31. Date filed (Month, Day, Year) SEP 28 32. Registrar's Signature State Registrar

**ORIGINAL** 

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** est. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Howard County General Hospital Howard Columbia 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days 1 □ M 2 🗙 F 73 Director 215 34 5772 Feb 2, 1934 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" --- any hours or other traumatic event. 10c. City, Town or Location 10a. State 10h. County 10d Inside City Limits 1 ☐ Yes 2 No **Funeral Director** MD Ellicott City Howard 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 8720 Ridge Road Apt 204 21043 United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 2 No 1 ☐ Yes 2 ☐ No Specify: Completed by Specify: 3 ₩idowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Secretary General Electric 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Edward E. Jessen Nora Hamson ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Deborah J. Goins/Niece 6730 Woodbine Rd Woodbine, MD 21797 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐Removal from State Crest Lawn Mem. Gard. 9-28-2007 4 ☐ Donation 5 ☐ Other (Specify) Marriottsville, MD 21. Signature of Funeral Ser 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. M01044 en Jakl ws. 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause each line. Immediate Cause (Final **Physician** NEUMONIA disease or condition resulting in death) /Medical Examiner Sequentially list conditions, Physician/Medical Examiner if any, leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last or Attending Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 23d. Date of delivery 3 Ectopic pregnancy Year Day 4☐Pregnant at time of death 5 Other (specify) 9 ☐ Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the pause of death? Completed by should be 3 Tobably 1 ☐ Yes 2∏ No 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No. 24a. Was an page 2 autopsy perform 2 4 25. Was case referred to medical examiner? Medical Certification: To Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes ,2**□**1110 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 27. Mann of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Matural Injury 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after deatl To the Funeral Director: Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ģ 4 Homicide 29a. Certifier 1 🖫 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely

State Registrar 31. Date filed (Month, Day, Year) SEP 26

(Check only

29b. Signature and title of certifier

Pl, Serte 32. Resistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 2. Date of Death Month 3. Time of Death 1. Decedent's Name (First, Middle, Last) Yea **Physician** 11:45 AM di 2007 0 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Nacility Name (If not institution, give street and number) Examiner KEGIENAL MEDICAL CENTER (NICOMICZ DALIS BURY ENINSULA If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Ox-13- Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex North **Funeral** Months 1 □ M 2 1 F Carolina Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 1 Yes 2 No Director comic DUR 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Numbe Vington by Funeral 14 Bace - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐
If Yes, Give
Year or Dates: Pages 1 and 2 should be filed within 72 hours after 2 No 1 Never Married 2 Married 1 ☐ Yes 2 No BLACK Baltimore, Maryland 21215-0036 Specify: 3 Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Department of Health and Mental Hygiene. Important: If item 27 Is marked other than ' any injury or other traumatic event, <u>the Me</u> Elementary/Secondary (0-12) College (1-4or 5+) MIDWAY CAL Driver 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Boone Hazel Ub ame ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1010 Adam JOHNSON (daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 22. Name and Address of Facility 917 W. ISA bella St.
Beynie Sinith 1 Bunal 2 □ Cremation 3 □ Removal from State Maryland Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee Salisbuny, md 21801 FUNERAL Home 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to infinite undecause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of). Completed by Physician/Medical Examiner he law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day 4☐Pregnant at time of death 5 Other (specify) ned by the at detached for I ☐ Yes 2 ☐ No 9☐Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autopsy perform 1 ☐ Yes 2 🗀 No Yes 1 Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one Be Hospital Other: 2 No 2 ER/Outpatient 3 DOA 1 ☐ Yes 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Unpatient Medical Certification: To this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Marmer of Death within 24 hours after occur.

To the Funeral Director: After to the funer Injury 5 ☐ Pending 1 ☐ Yes 2 ☐ No 2☐ Accident investigation 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 Homicide Gertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier (au m) D16725 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1340 31. Date filed (Month, Day, Year) SEP 26 ₩egistrar's Signature State Registrar

214-52-022

Roma White

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death September 21, Year 2007 **Physician** SHIRLEY ANN BOVILL 2:33 PM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Hours | Min. | Feb. 28, Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🖼 F 229-44-9308 70 1937 Virginia Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 X No Director Maryland Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21703 6885 Buttonwood Court USA r death v Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 X No If Yes, Give "natural", or Yes, Give 'ear or Dates: 1 ☐ Yes 2 No Specify: Specify: White ò 3 Vidowed 4 □ Divorced Completed 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Benton Williams Helen Elizabeth Huff ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Item 27 i other tra Kathleen Marie Glesner/Daughter 15 Boileau Court, Middletown, MD 21769 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Sept<sup>Date</sup> 26, permit. Pages 1 Department of H Important: If Ite any injury or oth 1 Burial 2 □ Cremation 3 □ Removal from State Gate of Heaven Cemetery 2007 Silver Spring, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22 Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd, W., Silver Spri 21. Signature of Funeral Service Licensee Spring, MD 20901 23a. Part1. Outer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** aneurysm 3 hvs disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Exam physician and s the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical attending | IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1☐Live birth 3 ☐Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>م</u> 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an ate has autopsy ector, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 No 1 Minpatient 2 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural (Month, Day Year) Injury 5 Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760 within 24 hours after death

To the Funeral Director:
completely filled in by the f

Baltimore, Maryland 21215-0036

3 ☐ Suicide 4 Homicide

6 Could not be determined

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29b. Signature and title of certifier

(Check only one)

D66276

29d. Date signed (Month, Day, Year)

MO 20\$50

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Haider 9210 CORPORATE BLVD, Suite 100

State Registrar

Medical

31. Date filed (Month, Day, Year) SEP 2 4 2007

32 Registrar's Signature

DHMH 17 Rev 1/2001

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2007 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year September 20, 2007 **Physician** Aram Yacoub Balekjian /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery General Hospital Olney Montgomery 8. Date of Birth (Month, Day, Year) Oct. 12, 1 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex Birthplace (State or Foreign Country)
 Egypt 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1**¥** M 2 □ F 216-50-5935 80 Director Usual Residence of Decedent with the Maryland r 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Directo Maryland Montgomery Garrett Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be n 20896 10908 Kenilworth Avenue USA Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? d other than "natural", or items event, the Medical Examiner m Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black White etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No <u>م</u> 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Biochemist Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be fi Department of Health and Mental I-Important: If Item 27 Is marked ott any Injury or other traumatic even Pages 1 and 2 should be in ment of Health and Mental in Hagop Balekjian Zarouhie Demirjian ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Hagop Balekjian/Son 4009 Decatur Avenue, Kensington, MD 20895 Sept. 26, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Dother (Specify) 2007 Gate of Heaven Cemetery Silver Spring, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 23a. Part1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 4110119 **Physician** /Medical erieheral arterial Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off Examiner physician and s the burial-trans Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month 5 Other (specify) ed by the a detached f 1 Yes 2 D No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2☐ No 24a, Was an certificate has birector, page 2 s performed 2 1 No or Attending Physician: funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 | Yes 2 | No Certification: To 1 Impatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? To the Hospital or Attending within 24 hours after death.

To the Funeral Director: Aft 1 Natural 5 Pending (Month, Day Year) Injury investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Ecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 18101 Prince Philip Drive, Olney, MD 20832 Ata Motamedi, MD 31. Date filed (Month, Day, Year) 32 egistrar's Signature

DHMH 17 Rev 1/2001

State

Registrar

2 4 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner ehab 4 Worchester If Under 1 Year Months Days 7. Age (In yrs. last birthday) Onow HLL Birthplace (State or Foreign Country) **Funeral** 1 M 2 F 24000 213 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location r 28a-f show notified at 10a. State 10b. County 1 Yes 2 No Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or any Injury or other traumatic event, the Medical Examiner must be r Completed by Funeral Pages 1 and 2 should be filed within 72 hours after death vnent of Health and Mental Hygiene. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. Yes 2 No f Yes, Give 'ear or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. DINCK 3 Widowed 4 □ Divorced 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Jorces 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 N Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Serv , or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest List only one cause on each line. 23a. Part1. Enter the diseas shock, or heart failure Immediate Cause (Final disease or condition resulting in death) DEMENTEA END Physician STAGE /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) 4☐Pregnant at time of death 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 o 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a. Was an autopsy performed? 2500 certificate 25. Was case referred to medical examiner? 26. Place of Death Check onl one Medical Certification: To Be Hospital: 1 ☐ Inpatient Other: 4 virsing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27, Manner of Death 28d. Describe how injury occurred 5 ☐ Pending Investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No ours after death.

neral Director: A
filled in by the fu 2 ☐ Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide determined within 24 hours a To the Funeral I Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature 91251 10062172 So Name and address of person who completed cause of death (Item 23a) (Type, Print)
Sharad R. Satyal, M.D. 1604 Market St. Pocomoico City BAZ

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

SEP 2 5 2007

32 Registrar's Signature

#### State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** OCT. ,2007 1 BETTY ANN CHISLEY /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner FT.WASHINGTON PRINCE FT.WASHINGTON HOSPITAL If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday) **Funeral** Months Days 1□ M 2 3 F 54 Director 9-7-1953 215-62-1318 Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a State 10b. County 10c. City. Town or Location 28a-f show items 23a or 28a-f sh ner must be notified Director CHARLES MD. INDIAN HEAD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12 PUEBLO CIRCLE 20640 U.S.A. by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: BLACK Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) BUILDING SERVICE WORKER CHARLES CO.BD.OF ED. permit. Pages 1 and 2 should be filed Department of Health and Mental Hygis Important: If Item 27 Is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be DOROTHY HALL MARION CHISLEY ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DOROTHY H. JORDAN-MOTHER 12 PUEBLO CR. INDIAN HEAD, MD. or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) OCT 8 Injury SACRED HEART CEM. 2007 LA PLATA, MD 22. Name and Address of Facility RAYMOND FUNERAL SERVICE, P.A. 21. Signature of Juneral Service Licensee M00479 any Ir **Physician** /Medical Examiner Examine Physician/Medical þ Completed Be (

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, Certification: To To the Funeral Director: completely filled in by the Medical

1 - Eura	0.19		ATA, MD. 20			
23a. Part1. Enter the disease, or of shock, or heart failure. List of	complications that sured the dea only one cause on son line.	th. Do not enter the mode	of dying, such as cardiac	or respiratory arrest,		Approximate Interval Between
Immediate Cause (Final disease or condition resulting in death)	aDue to (or as a conse		ardinasu	de disco	10	Onset and Death
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last	b. Due to (or as a conse	quence of):				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome pf pregr 1 Live birth 2 Fet 4 Pregnant at time of 9 Unknown	al death 3 Ectopic pre			23d. Date of Month	
Part II. Other significant condition	ns contributing to death but not re	sulting in the underlying ca	use given in Part I.			ute to the cause of death?  ☐ Probably 4 ☐Unknow
				24a. Was an autopsy performed'	prid dea	ere autopsy findings availab or to completion of cause of ath? Yes 2 \(\sumbole\) No
25. Was case referred to medical examiner?			26. Place of Dea	th (Check only one)		
1 Yes 2 → ₩0	Hospital: 1 ☐ Inpatient 2 €	ER/Outpatient 3 □ DO	Other: 4 Nursing H	ome 5 🗆 Residence	6 □Other	(Specify)
7. Manner of Death  1 □ Natural 5 □ Pending 2 □ Accident investiga	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	3c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how in	jury occurred	
3 Suicide 6 Could no 4 Homicide determin		nome, farm, street, factory,	office	28f. Location (Street City or Town, St	and Number ate)	or Rural Route Number,
29a. Certifier  (Check only one)  1 CertifyIng  2 Medical E	Physician: To the best of my kn xaminer: On the basis of examin and manner stated.	owledge, death occurred a ation and/or investigation,	at the time, date and place in my opinion, death occu	, and due to the cause rred at the time, date a	(s) and mann and place, an	er as stated. d due to the cause(s)
29b. Signature and title of centifier	Han	290.	License number 225 74	29d. [	Date signed (	Month, Day, Year)
30. Name and address of person w	no completed cause of death (Ite	m 23a) (Type, Print)	tr #30Z 1	Waldon	FIL	ND Z01002

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

10AM

Birthplace (State or Foreign Country)

10d. Inside City Limits

1x Yes 2 □ No

GEORGE

MD.

20640

Registrar DHMH 17 Rev 1/2001

State

2. Registrar's Signature

			1 - State of Maryland / Department of Health ar Certificate of Death	nd Mental Hy	giene Reg. No.2	2007	32410
ı	Physici	an	1. Decedent's Name (First, Middle, Last)	2. Date of D Month		Year	3. Time of Death
	/Medic	cal	4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of I	09	19	2007	10:55 AM
	Examin	ier	4a. Facility Name (If not institution, give street and number)  12721 Sullivan Gurt  Belts vill:			ounty of Death	eorges
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24		irth		lace (State or Foreign
w	Director		Usual Residence of Decedent  1 ☑ M 2 ☐ F 65 Yrs. Months Days Hours	04/30	/1942		inia
	yland now at		10a. State 10b. County 10c. City, Town or Location			1	0d. Inside City Limits
	e Mar Ba-f sl	Director	Maryland Prince George's Beltsville				1 🙀 Yes 2 🗆 No
	a or 2				_	en of What Coun	try?
	death with the Maryland ims 23a or 28a-f show r must be notified at	Funeral	12721 Sullivan Court 20705  11. Manital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, I	in? (Specify Yes or N	USA 0- 14	I. Race - Americ	an Indian,
5-0036	be filed within 72 hours after death with the Marylan ntal Hygione. driber than "natural", or thems 23a or 28a-1 show event, the Medical Examiner must be notified at	δ	3 ☐ Widowed 4 ☐ Divorced Year or Dates: 1968 1 ☐ Yes 2 ☐ No Specify:	Puèrto Rican, etc.)		Black, White, of Black, White, white, of Black, White, of Black, White, whi	etc. Lack
2	72 ho "natur	Completed	15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of life. DO NOT use retired)	of working	16b. Kind	of Business/Inc	lustry
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2	il Hygi other ent, tl	Be Cc		s Name <i>(First, Middle</i>			Center
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e, Mar	and 2 sho saith and n 27 is mi er traum		19a. Informant's Name/Relationship (Type. Print)  Loree Christian - Wife  19b. Mailing Address (Street and Number 12721 Sullivan Cour				Code) 705
Baltimore	permit. Pages 1 and 2 should be Department of Health and Mente Important: If Item 27 is marked any Injury or other traumatic ev		20a. Method of Disposition  1   Burial 2 □ Cremation 3 □ Removal from State  4 □ Donation 5 □ Other (Specify)  20b. Place of Disposition (Name of cemetery, crematory or other place)  MD Veteran s Cemetery 9	Date 9/26/2007		ation - City or To	
Dall	permit. Departimonts Imports any Inji		21. Signature of Funeral Service Vicensee  22. Name and Address of Facility  3401 Bladensburg	Fort Linc	oln Fu	uneral H	
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as ca shock, or heart failure. List only one cause on each line.		_	İ	Approximate Interval Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)  a. Lun Caucur metastatic to	hilar as	nd		Onset and Death
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	ertifica ing ph	Medi	IF FEMALE:				
O. DOX	To the Hospital or Attending Physician: The law requires that the death certif within 24 hours after decort. The the Turneral Director, After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)		230	d. Date of delive Month	ry Day Year
	that the ed by detac		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did	tobacco use	contribute to the	e cause of death?
Solds	equires en sign ould be	ed by	Auformation (2)		Yes 2□	10.70	ably 4 □Unknown
220	The law rate has be	Completed	Exposure to Agent Crange	24a. Was auto perl 1 Yes	s an opsy ormed? 2 No	prior to cor death?	osy findings available inpletion of cause of
A II d	Iclan: Sertific ector,	Be	25. Was case referred to medical examiner? 26. Place of	of Death (Check only			
5	Phys	<u>د</u>	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursi 27. Magner of Death 28a. Date of Injury 28b. Time of 28c. Injury at	ing Home 5 Res			)
	nding ath. r; Afte e fune	ation	27. Manner of Death    X   Natural   5		rilow injury c	ocurred	
	or Atte	Certification:	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location City or To	(Street and f own, State)	Number or Rura	l Route Number,
ב	spital o		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and	place and due to the	2 00000(0) 00		
	he Hos in 24 ho he Fur pletely	edical	(Check only one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death and manner stated.	occurred at the time	e, date and p	lace, and due to	the cause(s)
	With Tot Com	Σ	29b. Signature and title of certifier 29c. License number			signed (Month, I	
_		i	medeunt & Lotth D0050	500	Septe	inber i	25, 2007
R	-(15/4)		30. Name an address of person the completed cause of death (Item 23a) (Type, Print)  FORDITUR B. KOTLER ID NORTH BREENT STITET	SOU BAUTI	NDOL	MARUL	AND a 1201
	Sta		31. Date filed (Month, Day, Year) 32. Registrar's Signature	- IIVII	10100	1111140	71001
H	Registr	ar	SEP 2 6 2007 Green D. Sperke				

DHMH 17 Rev 1/2001

1_	For State Registra
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State of Maryland / Department of Health and Menta	l Hygie
Certificate of Death	Red

Physician	
/Medical	
Examiner	

Director

Funeral

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Completed

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Examiner

Physician/Medical

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Completed

Be

P

Certification:

Medical

**Physician** 

/Medical

Examiner

nding physician and use as the burial-trar

certificate

After

within 24 hours after co...

To the Funeral Director: Aft

funeral

P.O. Box 68760,

Division or Vital Records,

To the Hospital or Attending Physician:

in 5

1. Decedent's Name (First, Middle, Last) Frances Clough Clark

115 E. Main St.

2. Date of Death Month 9/25/2007

10d. Inside City Limits

4a. Facility Name (If not institution, give street and number)

10b. County

4b. City, Town, or Location of Death

4c. County of Death Oueen Anne's

**Funeral** 

5. Social Securify Number 214-30-9313 Usual Residence of Decedent

Sudlersville 7. Age (In vrs. last birthday) 1□ M 2 F Months Days Yrs. 74

10c. City, Town or Location

If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 4/6/1933 Hours Min.

9. Birthplace (State or Foreign

Director permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural" ~ " any injury or other traumatic even."

10a. State MD

Queen Anne's Sudlersville 1 X Yes 2 □ No

10e. Street and Number

10f. Zip Code

10g. Citizen of What Country?

115 E. Main St. 11. Marital Status

1 ☐ Never Married 2 Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 2 If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 X No Specify:

14. Race - American Indian White

15. Decedent's Education (Specify only highest grade completed)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

21668

16b. Kind of Business/Industry

Elementary/Secondary (0-12)

College (1-4or 5+)

Secretary

Education

17. Father's Name (First, Middle, Last) Paul Clough

Edith Thompson

18. Mother's Name (First, Middle, Maiden Surname)

19a. Informant's Name/Relationship (Type. Print)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PO Box 237

Sudlersville, MD

21668

Greg Clark/Son 20a. Method of Disposition

1 ₺ Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place) Sudlersville Cem.

9/28/2007

Sudlersville,MD

21. Signature of Funeral Service Licenses

130 Speer Rd. Chestertown, MD 21620

Immediate Cause (Final disease or condition resulting in death)

LUNG CANCE Due to (or as a consequence of):

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

Due to (or as a consequence of):

23d. Date of delivery Month Day

Year

IF FEMALE:

23b. Was decedent pregnant

in the past 12 months? 1 ☐ Yes 2 🕱 No 9 Unknown

23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

3 DEctopic pregnancy 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify)

2 ER/Outpatient 3 DOA

23e. Did tobacco use contribute to the cause of death?

24a. Was an

1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown

autopsy 2 No 1∐ Yes

28d. Describe how injury occurred

24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 □Other (Specify)

27. Manner of Death Natural 2 Accident

4 Homicide

5 Pending investigation 6 Could not be determined 3 ☐ Suicide

25. Was case referred to medical examiner?
1 ☐ Yes 25 No

28a. Date of Injury (Month, Day Year) 28b. Time of 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 Inpatient

28c. Injury at Work? 1 Tyes 2 No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1 Decrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

D0041587

29d. Date signed (Month, Day, Year) 25 07

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Chestito. un, MO 21620 177 Speer Rd

32. Reg

Hospital:

31. Date filed (Month, State Registrar

**ORIGINAL** 

DHMH 17 Rev 1/2001

20c. Location - City or Town, State

22. Name and Address of Facility Fellows, Helfenbein&Newnam

Approximate Interval Between Onset and Death

		•	For State Registrar	State of Maryla				ealth an Death	nd Mer		giene Reg. No.2007	7 32412
	Physici		1. Decedent's Name (First, Middle, Last) Paul W. Crouch	-		-				Date of Dea Month	ath Day Year	3. Time of Death
	/Medic Examin Funeral Director		4a. Facility Name (If not institution, give st Easton Memo	rial Hosi	pital rs. lasi birthday) Yrs.	Ec	STC er 1 Year	Location of D	Hrs. 8.	Date of Birtl (Month, Day	4c. County of De	
	Usual Residence of Decedent								10d. Inside City Limits 1 ☐ Yes ※XXNo			
	h with the 23a or 28e st be notii	ai Director	10e. Street and Number 2085 Wayne Roa	d, Apt. #	208		ip Code 1720	2			10g. Citizen of What 0	Country?
9036	d within 72 hours after death with the Maryland jiele. I then "natural", or Items 23s or 28e-f ehow I're Medical Examanar in the maillied at	by Funerai	11. Marital Status 1 Never Married 2 Married 3 Midowed 4 Divorced	2. Was Decedent Ever in Armed Forces?  1X Yes 2 \( \sum \) No 9/ If Yes, Give Year or Dates: 12/2	726/42 28/45		edent of H ecify Cuba X No	ispanic Origin n, Mexican, F Specify:	n? (Specify Puerto Rica	Yes or No- an, etc.)	Sanaitu	nerican Indian, ite, etc. hite
21215-0036	d within giene. rr then	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)		16a. Deced (Give life. Teac	kind of w DO NOT		<i>furina</i> most o	of working		16b. Kind of Busines Secondar Educ	,
Maryland	2 should be filed and Mental Hygi Is marked other eumatic event.	To Be C	17. Father's Name (First, Middle, Last)  Arthur C.J. C					J. L	ucie	A. 1		
	ss 1 and 2 should of Health and Men item 27 is marke other treumatic		19a. Informant's Name/Relationship (Type William L. Crou	ch	5451	Dun	gan I	Lane,	York,	Penns	sr, City or Town, State, sylvania 1	7406
Baltimore,	permit. Pages 1 Depertment of H Important: If ite eny Injury or ott		20a. Method of Disposition  1 Burial Tornation 3X Re 4 Donation 5 Other (Specify)	moval from State	o. Place of Dispo cemetery, crer ler Memo cemation	matory`or prial Ser	Home Vices	2	Date 27, 2		20c. Location - City of Harrisburg Pennsylva	,
Bai	permit Deper Impor eny In		21. Signature of Funeral Service Licease	Olompo -00		S.	Churc	h Stre	eet,	Wayne:	sboro, PA	
	Physician /Medical Examiner	niner	23a. Part1. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a con-	C(C) sequence of):	A					1-EAK	Approximate Interval Between Onset and Death DAYS
x 68760,	death certificate be executed e attending physicien and of for use as the buriat-transit	Physician/Medicai Examin	that initiated events resulting in death) Last c.	Due to (or as a con-		-						
P.O. Box	e f f	hysician/	23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown	ic. If yes, outcome of pre  1 Live birth 2 F  4 Pregnant at time of 1 Unknown	etal death 3	□Ectopic □ Other (	pregnancy specify)				23d. Date of d Month	elivery Day Year
	w requires that I been signed by should be deta	þ	Part II. Other significant conditions conditions		resulting in the u	inderlying	cause giv	en in Part I.			obacco use contribute res 2 🗆 No 3 🗀	to the cause of death?  Probably 4 Wunknown
24a. Was an 24b. Were autopsy fin prior to completic death?  1 1 Yes 2 Mo 1 Yes 2 Mo												
<u> </u>	Physicien: this certific ral director,	o Be	25. Was case referred to medical examiner?  1 Yes 2 No	ospital: 1 Inpatient	2 ☐ ER/Outpatier	nt 3 🗆 [	Oth Oth	ar.		heck only o	ne) dence 6 ∐Other (S)	nacifu)
28d. Date of Injury 28b. Time of Injury 28b. Time of Injury 28b. Injury al Work?  1 Shatural 5 Pending investigation 28b. Place of Injury 28b. Time of Injury 3 Work?  1 Yes 2 No  28b. Location (Street and Number of Injury 28b. Place of Injury 3 No. 1 Pending investigation 3 Suicide 6 Could not be determined by the injury 4 No. 1 Pending investigation 28b. Place of Injury 4 No. 1 Pending investigation 28b. Place of Injury 4 No. 1 Pending investigation 28b. Place of Injury 4 No. 1 Pending investigation 28b. Place of Injury 4 No. 1 Pending investigation 28b. Place of Injury 5 No. 1 Pending investigation 28b. Place of Injury 5 No. 1 Pending investigation 28b. Place of Injury 5 No. 1 Pending investigation 3 Pending invest								, and the same of				
Division	i Dift o	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - A building, etc. (Sp	ecify)					City or Tox		
	4 T P 9	edicai	29a. Certifier 1 1 Certifying Phys (Check only 2 Medical Examin	ician: To the best of my er: On the basis of exan and manner stated.	knowledge deat nination and/or in	t Jocume vestigation	d at the tir on, in my o	ne, date and ; pinion, death	place, and occurred	dua to the a	cause(s) and Tamer date and place, and d	ue to the cause(s)
	To the Hos within 24 h To the Fur completely	Me	29b. Signature and title of certifier			2	9c. Licens	number	· · ·		29d. Date signed (Mo	nth, Day, Year) v 25, 2007
wi.	1-8+1		30. Name and address of person who con		<sub>Item 23a)</sub> (Type, ton Stre	Print)				·	عرا الم	,
	Sta Registi		31. Date filed (Month, Day, Year) SEP 2 7 20	32. Registrar's Si	gnature	- ente						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2007

Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Year **Physician** 1:25 aM Adelaide M. Curren September 21, 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 12940 Tourmaline Terrace Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Min 1 M 2 F Yrs 90 Director New York 129-12-4601 August 2, 1917 Usual Residence of Decedent filed within 72 hours after death with the Maryland a or 28a-f show t be notified at 10a. State 10c. City, Town or Location 10d, Inside City Limits 1 ☐ Yes 2 X No Director Maryland Montgomery Silver Spring 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country "natural", or items 23a 12940 Tourmaline Terrace 20904 II.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14 Bace - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify þ Specify. 3 X Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16h Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) the 12 Homemaker Own Home is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be nent of Health and Mental Frederick Emken Mary Kenney ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 is any injury or other trau once. Deborah Curren-Aquino - Daughter 12940 Tourmaline Terrace, Spring Spring, Maryland 20904 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven Cemetery 9/24/2007 Silver Spring, Maryland 21. Signature of Funeral Service License 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediale Cause (Final Physician disease or condition resulting in death) Congestive Heart Failure Hours /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical the as attending p 23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☒ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) the detached 9 Unknown 9 TUnknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Tyes 2⊠ No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has page 2 autopsy certificate 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 🖾 Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA 2 this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Hospitai or Attending 1 X Natural 5 ☐ Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident hin 24 hours after deal n by the 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide filled 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title dertifier 29c. License number 29d. Date signed (Month, Day, Year) ပ္ 0 Mescale D02338 September 22, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3929 Ferrara Drive, Silver Spring, Maryland 20906 Richard DElaney, M.D., 32 Registrar's Signature

State

Registrar

31. Date filed (Month, Day, Year)

SEP

2 4 2007

State of Maryland / Department of Health and Mental Hygiene Stata
RegistrarAMEND#28cperMD9/25/07,BMW,McCo Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death **Physician** Warren 9.206 M Wayne Crump 20 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Hebrew Home of Greater Washington Rockville Montgomery If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 180 M 2□ F 449-80-0263 Yrs Director Texas Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits 77 is marked other than "natural", or itsme 23a or 28e-f show troumatic svent, the Medical Examinar must be notified at 1 ☐ Yes 👷 🖸 No Director Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3220 Beret Lane 20906 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. filed within 72 hours after 1x∃Yes 2□No If Yes, Give Year or Dates: Vietnam 1 Never Married 2F Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 € No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 5+ Minister Religion 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be and Mental P Pages 1 and 2 should be Ocie Crump Reva Edmondson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health if Donnis D. Crump/Wife 3220 Beret Lane, Silver Spring, MD 20906 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Sept. Date 24, permit. Pages 1
Depertment of H
Important: If Ite
any injury or ott 1 XBurial 2 Cremation 3 X Bemoval from State Heartland Cemetery 2007 4 ☐ Donation 5 ☐ Other (Specify) Brownwood, Texas 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. والمحاط W 500 University Blvd. W., Silver Spring, MD 20901 soule 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that is littled enter the list and ent Examiner The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760 Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Day Month Year 4☐Pregnant at time of death 5 Other (specify) P.O. I 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 1 ☐ Yes 2 ☐ No 1 Yes 2 No or Attending Physician: . After this certifical funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 1 🗌 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 1 Natural 5 Pending within 24 hours after death.

To the Funerel Director: A completely filled in by the fu 1 Yes 'Z 100 investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) mem 23a) (Type 30. Name and address of person completed cause of death 31. Date filed (Month, Day, Year) SEP 2 4 32 Registrar's Signature State 2007 Registrar

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		- For State Certificate of Registrar Certificate of			Reg.	No. 200	7 3241
Physiciar Medical Examin	er	1. Decedent's Name (First, Middle,Last)  KEYONI D. CARTER			Date of Death Month D September 2		3. Time of Death 2200 hrs
		4a. Facility Name (if not institution, give street and number) Prince George County Hospital Center	4b. City, Town, or Cheverly	Location of Death		4c. County of Death Prince George	·
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)  578-12-1784 1 M 2 F 18 Yrs	If Under 1 Year Months Day	. //	3. Date of Birth(I	MM/DD/YYYY) 9. Bir Foreig Co	
Maryland 28a-f show any d at once.		Usual Residence of Decedent  10a. State		5			10d. Inside City Limits 1 Yes 2 X No
with the Maryland ms 23a or 28a-f she be notified at once	Director	10e. Street and Number 6500 Ronald Rd. #201	10f. Zip Code 207	4.3	10g.	Citizen of What Cou	ntry?
ler death with	Fune	11. Marital Status 1 X Never Married 2 Married Armed Forces? 1 Yes 2 X No	as Decedent of Hi	spanic Origin? ( Speci n, Mexican, Puerto Ric		14. Race - Amer White, etc.	can Indian, Black,
36 n 72 hour nan "natu lical Exan	Completed by	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4 or 5+)	nt's Usual Occupa	tion (Give kind of work b. DO NOT use retired		6b. Kind of Business/	
21215-0036 hould be filed within 72 nd Mental Hygiene. is marked other than atic event, the Medical	Be Com	17. Father's Name (First, Middle, Last)  Keith Carter	udent	18.Mother's Name (Fi	rst, Middle, Mai 1e Rori	,	
Z. 2 4 2 2 1		19a. Informant's Name/Relationship (Type, Print)  Monique Rorie/Mother  19b. Mailin. 650 Cap	g Address (Stree 0 Rona.	et and Number or Rura Ld Rd. #2 Pights MI	Route Numbe	r, City or Town, State	
ore, ite		20a. Method of Disposition  1 X Burial 2 Cremation 3 Removal from State  4 Donation 5 Other Specify:  20b. Place of Disposic crematory or ot Mt. Oliv	her place)	eights MI metery, D		washing	
			Name and Addres Lurray I 804 Geo	uneral F	Iome	Washingt	20011 Pn, DC
Physician /Medical Examiner		failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):			spiratory arrest	, snock, or near	Approximate Interval Between Onset and Death
	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Universitying Cause					
uted nd ransit	Exa	(Disease or injury that initiated events resulting in death) Last    C.   Due to (or as a consequence of):  d.					
760, icate be executed sphysician and the burial - transit	Medical	X UNPENDED  AMENDED, 7, perME, g873, 11/2  IF FEMALE: 23c. If yes, outcome of pregnancy	2/07 TT			22d Date of deliver	
	Physician/IV	3b. Was decedent pregnant in the past 12 months?	etal death 3 ther (Specify)	Ectopic pregnancy	<b>′</b>	23d. Date of deliver Month	y Day Year
i, P.O. Be ires that the de signed by the	2	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause	given in Part I.		cco use contribute to	the cause of death?
cords aw requ has been 2 should	Completed				24a. Was an autopsy performe	prior to	topsy findings available completion of cause of
Vital Rec ysician: The his certificate director, page	Be -	25. Was case referred to medical examiner?  Hospital: 1 Innatient 2 FR/Dutnatient		of Death (Check only	/ one)		
of Vit	의	1 ✓ Yes 2 No Tospital 1 Inpatient 2 ✓ ER/Outpatient 27. Manner of Death 28a. Date of Injury 28b. Time of I		Other Nursing H		esidence 6 Othe	:
ion of tending Pheath. tor: After the funeral	ation	1 X Natural 5 Pending 2 Accident Investigation (Month, Day, Year)		Yes 2 No			
Division To the Hospital or Attentwithin 24 hours after death To the Funeral Director. Completely filled in by the	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, streed (Specify)	et, factory, office t	ouilding, etc. 28	f. Location (Stre or Town, Stat		ral Route Number, City
within 24 h	edical	29a. Certifier 1 ☐ Certifying Physician: To the best of my knowledge, death occur one) 2 ✓ Medical Examiner:On the basis of examination and/or investigating and manner stated.	tion, in my opinior	n, death occurred at th	e time, date an	d place, and due to th	e cause(s)
	2	29b. Signature and title of certifier	29c. Licens			9d. Date signed <i>(Mo</i> September 26, 2	
		30. Name and address of person who completed cause of death (Item 23a)  Ana Rubio MD. Assistant Medical Examiner 111 Penn S	Street, Baltimo	ore, MD 21201			
Stat Registra		31 Date filed (Manth Day Year) 32. Registrar's Signature					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2007 Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) **Physician** 9/30/2007 Stephrn John Chris 11:55 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Adamstown

H Under 1 Year | H Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Buckinghams Choice Health Cr Ctr Frederick Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral ™** M 2 F Yrs. Director 378-09-9741 93 PA 11/1/1913 Usual Residence of Decedent permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other then "natural" or home only no other traumath. 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Director MD Frederick Adamstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3200 Baker Circle H012 <u> 21710</u> Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ∏ Yes 2 M No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Aeronautical Engineer Engineering 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 Stephen J. Chris Mary Doxbeck 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 105 Meadows Lane NE Leesburg, VA 20176 Stephanie Chris Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Smithsburg Cremation 10/5/2007 Smithsburg, Maryland 22. Name and Address of Facility Keeney & Basford P.A. F.H. 21. Signature of Funeral Service Li MO1176 106 East Church Street Frederick, MD 21701 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Conyestive

Due to (or as a confequence of): Heart Failure **Physician** disease or condition resulting in death) /Medical Examiner Coronary Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Examiner Due to (or as a consequence of): Physician/Medical the IF FEMALE nse 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by In fulciencer 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown page 2 should Certification: To

The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, or Attending death.

attending physician certificate has : After this certification of the funeral director, it within 24 hours after death To the Funeral Director: filled in by the completely

	/)	
		24a. Was an autopsy performed? 1
25. Was case referred to medical	26. Place of Death	(Check only one)
examiner? 1 ☐ Yes 2 No	Hospital: 1   Inpatient 2   ER/Outpatient 3   DOA   Other: 4   Nursing Hom	ne 5 Residence 6 Other (Specify)
27. Manner of Death 1. Antural 5 ☐ Pending 2 ☐ Accident investigati	28a. Date of Injury (Month, Day Year)  28b. Time of Injury 28c. Injury at Work?	8d. Describe how injury occurred
3 Suicide 6 Could not 4 Homicide determine		8f. Location (Street and Number or Rural Route Number, City or Town, State)
	Physician: To the best of my knowledge, death occurred at the time, date and place, a	

29c. License number

00058726

Medical

one)

29b. Signature and title of certifier

State Registrar

Yvette Warren 31. Date filed (Mon

30. Name and address of prson who completed cause of death (Item 23a) (Type, Print)

3000 - D Registrar's Signature

29d. Date signed (Month, Day, Year)

10-1-07

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item 18 per fin e872 10 9 07 vt.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.? 1. Decedent's Name (First, Middle, Last) 2. Date of Death <sup>Day</sup> 23, **Physician** 1050 A M SEPTEMBER 2007 NELLIE CAMPBELL /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner WESTERN MARYLAND HEALTH ALLEGANY CUMBERLAND If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, 04-15-1922 5. Social Security Number Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1 □ M 2 🔀 F Director WOODRÚFF SC 242-26-8735 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10h County 10d. Inside City Limits ns 23a or 28a-f show must be notified at 1 ☐Yes 2☐No Director HAMPSHIRE THREE CHURCHES WV the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 26765 US HC 74 BOX 3 D Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Int: If Item 27 Is marked other than "natural", or itel 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No altimore, Maryland 21215-0036 Specify Specify: WHITE þ 3 XWidowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) TEXTILE FACTORY WORKER 6 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be KATIE <del>REARL</del> HEBERT ဥ MARION HENRY CARTER 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BOC 3 D THREE CHERCHES WV 26765 HC 74 CAROLYN SUE RUNKLES 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: if Itel
any Injury or ott 1 ☐ Burial 2 🖾 Cremation 3 🗌 Removal from State 4 Donation 5 ☐ Other (Specify) 09-25-2007 MORGANTOWN WV WVU MEMORIAL VAULT 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hafer Funeral Service, P.A. 1302 National Hwy., LaVale, MD 23a. Part1. Enter the disease shock, or heart failure. hs that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, use on each me. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** EREBROVASC disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 months?
1 ☐ Yes 2 No
9 ☐ Unknown for Month Dav Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Nuknown certificate has been si rector, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1□ Yes 2□ No 1 ☐ Yes To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 npatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28c. Injury at Work? Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No death. neral Director: A 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours at To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) 29c. License number 29b, Signature and title of certifier 29d. Date signed (Month. Dav. Year) D36766 SEPTEMBER 24, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 924 Poonas SETON DR, CHARGELAND, MD 21502 VIK

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month,

Day, Year)

OCT 0 9 2007

gistrar's Signature

32,

State of Maryland / Department of Health and Mental Hygiene 32418 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** JOHN JEREMIAH DUGAN OCT.4,2007 3:15A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** 8260 CHESTNUT HILL PLACE WELCOME CHARLES 8. Date of Birth (Month, Day, Year) 9-28-1942 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Funeral Months Days 1√2 M 2 □ F Hours 218-38-9775 65 Director MARYLAND Usual Residence of Decedent and 2 should be filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location r 28a-f show notified at 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No Director MD CHARLES WELCOME 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a or Examiner must be r 8260 CHESTNUT HILL PLACE 20693 S A A.

14. Race - American Indian, Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify þ 3 Widowed 4 Divorced 'natural"; WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) ARCHITECT OF THE FOREMAN CAPITOL 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be JOHN JEREMIAH DUGAN ဂ္ REGINA MARY GRAEBENSTEIN 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8260 CHESTNUT HILL PL.

e of Disposition (Name of Date DAWN-MOREE DUGAN / WIFE WELCOME, MD 20693 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages 1.
Department of He Important: If iten any Injury or oth once. OCT. 4, 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) METROPOLITAN F.S. ALEXANDRIA, VA 2007 21. Signature of Funeral Service Licenses RAYMOND FUNL.SERVICES, P.A. 5635 WASHINGTON AVE. I.A not enter the mode of dying, such as cardiac or respiratory arrest, LAPLATA, MD 20646 23a. Part1. Enter the disease, or complications to t caused the death shock, or heart failure. List only one care on each line. Approximate Interval Between Onset and Death immediate Cause (Final Physician -01 10 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Lines Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed and burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical the as IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed Yes 2 1□ Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 2 ER/Outpatient 3 DOA Residence 6 ☐Other (Specify) Manner of Deal 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 ☐ Natural 2 ☐ Accident 5 Pending investigation Injury 1 ☐ Yes after death Director: the 6 ☐ Could not be 3☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 15 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 29 31. Date filed (Month, Day, legistrar's Signature State Registrar 2007

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

	••
William Harry Donnelly	State of Maryland / Department of Health and Mental I

	1- For State Cereseistrar	rtificate of Death	Reg. No.	2007 3211
Physician/ Medical Examiner	1. Decedent's Name (First, Middle,Last) William Harry	Donnelly	2. Date of Death  Month Day  September 28,	3. Time of Death 2007 2253 hrs
	4a. Facility Name (if not institution, give street and number)  Cumberland Memorial Hospital	4b. City, Town, or Location of Cumberland	Death 4d	c. County of Death Allegany
Funeral Director	5. Social Security Number 6. Sex 7. Age (in yrs. 182–42–2292 1 X M 2 F 56	last birthday) If Under 1 Year If Under  Months Days Hours		/DD/YYYY) 9. Birthplace (State or Foreign Panney ] yan
Maryland 28a-f show any d at once. rector	MD Allegany	Town or Location  Cumberland		10d. Inside City Limits 1 Yes 2 XNo
with the Maryland ns 23a or 28a-f sho be notified at once.	10e. Street and Number 14601 Burbridge Road	10f. Zip Code 21502	1 -	izen of What Country? USA
er death	11. Marital Status  1 X Never Married 2 Married Armed Forces? 1 Yes 2 X No 3 Widowed 4 Divorced If Yes, Give Year	I.S. 13. Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, In Yes 2 X No specify:		14. Race - American Indian, Black, White, etc.  Specify: White
215-0036 be filed within 72 hours after death with the Maryland ntal Flygiene. rked other than "natural", or items 23a or 28a-f she ent, the Medical Examiner must be notified at once Be Completed by Funeral Director	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4 or 5+)  12	16a. Decedent's Usual Occupation (Give ki during most of working life. DO NOT u		Kind of Business/Industry  Construction
21215-0036 uld be filed within 7 Mental Hygiene. marked other than cevent, the Medica	17. Father's Name (First, Middle, Last) William Donne	18.Mother's	Name (First, Middle, Maiden zabeth	
MD 21 d 2 should lth and Me n 27 is ma aumatic ex	19a. Informant's Name/Relationship (Type, Print)  Jeff Baney / Prison Official	19b. Mailing Address (Street and Numb	oad, Cumberla	nd, MD 21502
Baltimore, MD 21215-0036 pernit. Pages I and 2 should be filed within 72 hours all Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural' injury or other traumatic event, the Medical Examine To Be Completed by	1 X Burial 2 Cremation 3 Removal from State	· ·	10/5/2007 P	hiladelphia, PA
Bal permi Depar Impo injur	fold a lider	404 Decatur St	reet, Cumberl	and, MD 21502
Physician /Medical `xaminer	Part I. Enter the disease, or complications that caused the death failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of the death failure).	with complications	rdiac or respiratory arrest, sh	ock, or heart Approximate Interval Between Onset and Death
Red State of the s	Sequentially list conditions, if any, leading to immediate course. Enter Uncertainty Course (Disease or injury that initiated events resulting in death) Last  b. Due to (or as a consequence of Due to (or as a conseque			
760, crate be executed the burial - transit	d.  XUNPENDED  AMENDED. #23a,27, perME.gi		23	3d. Date of delivery
Records, P.O. Box 68760,  The law requires that the death certificate be executed icate has been signed by the attending physician and page 2 should be detached for use as the burial - transit Completed by Physician/Medical Exa	23b. Was decedent pregnant in the past 12 months?  1		pregnancy	Month Day Year
S, P.O. I uires that the a signed by the deceache ed by Ph	Part II. Other significant conditions contributing to death but not	resulting in the underlying cause given in Par	1 Yes 2	
of Vital Records, in Physician: The law require. The the requirement of the this certificate has been significated irrector, page 2 should be 1: To Be Completed			24a. Was an autopsy performed?	
Vital Rec nysician: The this certificate director, page o Be Con	25. Was case referred to medical examiner?  1 ✓ Yes 2 No  Hospital: 1 Inpatient 2 ✓	26.Place of Death (0  ER/Outpatient 3 DOA Other		ence 6 Other:
_ = . \	27. Manner of Death  1 X Natural 5 Pending 2 Accident Investigation	28b. Time of Injury 28c. Injury at Work?	· · · · · · · · · · · · · · · · · · ·	jury occurred
Division To the Hospital or Attendit within 24 hours after death. To the Funeral Director: A completely filled in by the for		nome, farm, street, factory, office building, etc	28f. Location (Street a or Town, State)	and Number or Rural Route Number, City
To the Hos within 24 h To the Fur completely	Check only  1 Certifying Physician: To the best of my knowled one)  2 Medical Examiner: On the basis of examination a and manner stated.  29b. Signature and title of certifier	and/or investigation, in my opinion, death occ	urred at the time, date and pl	lace, and due to the cause(s)
	30. Name and address of person who completed cause of death (Item	29c. License number O.C.M.E. 00		Date signed (Month, Day, Year) ptember 29, 2007
	Theodore M. King, Jr., MD. Assistant Medical I	Examiner 111 Penn Street, Balt	imore, MD 21201	
State Registrar	OOT I D coarl &	5 Souls		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amended #10b**1** - State Registrar 09/24/07, T.M., Kent Co. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 12:27P M Gloria Sieger Durham 09/20/2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Chestertown Nursing & Rehab Chestertown Kent If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days 1 □ M 2 🗓 F 162-03-2753 94 Director 02/13/1913 PA Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10b. County Queen Anne 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 X No Director Kent Church Hill 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 132 Blue Note Farm Ln. 21623 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: White Completed by 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Hiram Franklin Sieger Fanny Emily Plant 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James R. Durham III/Son 132 Blue Note Farm Ln. Church Hill, MD 21623 ce of Disposition (Name of Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Chesapeake Cremation 9/22/2007 Stevensville,MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of FacilityFellows, Helfenbein & Newnam 21. Signature of Funeral Service Licensee rik 5 130 Speer Rd. Chestertown, MD 21620 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Zypar **Physician** Al-heimers /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate caus. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) The law requires that the death certificate be executed burial-trar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician as attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnaricy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) \_ ed by the a 9 Linknown 9 Unknown signed by the sign of the sign Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>ک</u> multiple CVA; Pavoxyomal 44.65 1 🗌 Yes No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No Pul. HTN: 24a. Was an autopsy performed? certificate has Yes director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this After this funeral of 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending investigation Injury within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No death. 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a, Certifier

State Registrar 29b. Signature and title of certifier

To the I

Tm

100 Brocon St.

29c. License number

Chastartown AD 21620

29d. Date signed (Month, Day, Year)

and manner stated.

32. Registar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2007

Steeldard MD

			State of Maryland / Department of Health and Me  1 - State Registrar  Certificate of Death	/11	07 32421
	Physici	ian	1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day	3. Time of Death
F	/Medi		4- 5-39-31	4c. County of	201 0933 M
2	LAAIIII	ici	Chester River Hospital Center Chestertoun	Ker	21
	Funeral Director		5. Social Security Number 6. Sex 1 Months Days Hours Min. 1 Was Residence of Decedent	8. Date of Birth Month, Day Year)	9. Birthplace (State or Foreign Country)
	how lat	L	10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits
	the Ma 28a-f s otified	Director	10e. Street and Number 10f. Zip Code	T 10 011	T⊟¥es 2 □ No
	death with the Maryland rms 23a or 28a-f show r must be notified at	al Dir	100. Street and Number  101. Zip Code  2/22	10g. Citizen of W	nat Country?
	er deal	Funeral	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispanic Origin? (Specify Cuban, Mexican, Puerto R	cify Yes or No- Rican, etc.) 14. Race	~ American Indian, , White, etc.
980	72 hours after natural", or Ite diral Examine	by	3 ☐ Wildowed 4 Divorced If Yes, Give Year or Dates:	Specify:	RKAV.
5-0036	72 ho "natur dical l	eted	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working	16b. Kind of Bus	siness/Industry
2121	d within jiene.	Completed	Elementary/Secondary (9.12) College (1-4or 5+)	Soular	Was 1 Rona
	iges 1 and 2 should be filed within 72 hours after death with the Marylan to f Health and Mental Hygene. If Item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	Be	17. Fatber's Name (First, Middle, East)	(First, Middle, Maiden Surname	9)
Maryland	should be and Mental marked o	은	19a Informant's Name/Relationship (Type, Print) , 19b. Mailing Address (Street and Number or Rural	Route Number Pity or Town	State Zin Code)
, Ma	permit. Pages 1 and 2 shoul Department of Health and Milmportant; If Item 27 is marl any Injury or other traumatione.		BRING DOUGLOS (dANIGHER) GONSAMERLIGIDO CH. APA	Ho Clastertua	d. M.) 2/(a-27)
Baltimore,	iges 1 nt of He if Iten or oth		20a. Method of Disposition  20b. Place of Disposition (Name of cernetery, crematory or other place)  Date of Disposition (Name of cernetery, crematory or other place)	ate 20c. Location - 0	City or Town, State
altim	nit. Pa artmer ortant: Injury e.		4 □ Donation 5 □ Other (Specify)  SANATOWN  10/6  21. Signature of Funeral Service Licensee  22. Name and Address of Facility	107 Red 90	144 md
ä	Depa Impo any Ir		Dannie y. Shaw Bennie Smith	Funeral ?	Home
	***		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or heart failure. List only one cause on each line.  Immediate Cause (Final	respiratory arrest,	Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)  a.   CARDTO FULTION AND ARRIVET  Due to (or as a consequence of):		
l,	Examiner	_	Sequentially list conditions, b. Appotausion		
	uted	Examiner	cause. Enter Underlying Cause (Disease or righty) that initiated events resulting in death) Last resulting in death) Last	m 10-15% wi	72
90,	ate be executed thysician and the burial-transit			Melina	
68760,	ficate by physical from the position of the po	edical	d Type II maketer		
Вох	death certific attending p I for use as	an/M	IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy		of delivery
Ö.	The law requires that the death certific tle has been signed by the attending p tage 2 should be detached for use as	Physician/Me	in the past 12 months?    1	Mon	th Day Year
Δ.	res that t signed by be detac	by Ph		23e. Did tobacco use contri	bute to the cause of death?
ord	w require been sig should b	ted b	Hypenteusem.	1∉ Yes 2 No	3 ☐ Probably 4 ☐ Unknown
Records,	he law e has b ige 2 sl	Completed		autopsy   pr	lere autopsy findings available fior to completion of cause of eath?
Vital		Be Co		1 Yes 2 No 1	□Yes 2□No
or V	Physiclan; this certific al director,	은	1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 FER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home	e 5 ☐ Residence 6 ☐ Othe	
	ding I. After funer	ation	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 1 ■ Natural 5 □ Pending (Month, Day Year) Injury M 28c. Injury at Work? 1 □ Yes 2 □ No	3d. Describe how injury occurre	d
Division	i or Attendi after death. Director; A d in by the fu	Certification:	3 ☐ Suicide 4 ☐ Homicide  3 ☐ Suicide 4 ☐ Homicide  4 ☐ Homicide  28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)	Bf. Location (Street and Number City or Town, State)	r or Rural Route Number,
	spital			nd due to the cause(s) and man	ner as stated
	To the Hospital or Atten within 24 hours after deatl To the Funeral Director: completely filled in by the	edical	(Crisic only opinion, death occurred one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred one)	d at the time, date and place, a	nd due to the cause(s)
	With Con	Ž	29b. Signature and title of certifier  29c. License number	29d. Date signed	(Month, Day, Year)
7			30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print)	1/291	
			John C. ATCKATSAL TR. Mb. 223 High Street Ch	les tes Fourse, no	18 21620
	Sta Registr		CEB 9 0 2007 \ Sh	_	

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dward N. David		State of Maryland / Department o  -For State Certificate o				7 3242
Dhariaia		Registrar  1. Decedent's Name (First, Middle,Last)	i Deatri	Reg. I 2. Date of Death		3. Time of Death
Physicia Iedical Examiı	-	Edward N. Davids	on	Month Da September 8	y Year , 2007	1720 hrs
		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
		7930 Oakwood Road	Glen Burnie	150	Anne Arundel	
Funeral	T	5. Social Security Number 6. Sex 7. Age (In yrs, last birthday)	If Under 1 Year If Under 24Hrs  Months Days Hours Min		MM/DD/YYYY) 9. Birth Foreign	1
Director		122-16-4152 1 XM 2 F 81 Yr		May 31	,1926 Cou	ntry)New Yorl
-	F	Usual Residence of Decedent	tion			10d. Inside City Limits
w any						1 Yes 2 X No
Aaryland 28a-f show 1 at once.	ġ	Maryland Anne Arundell  10e. Street and Number	Glen Burnie	10g.	Citizen of What Coun	
e Mar	Director					,
ith the		7930 Oakwood Road  11. Marital Status 12. Was Decedent Ever in U.S. 13. W	21060-0416 as Decedent of Hispanic Origin? (Sp		S.A.	an Indian, Black,
ath w	Funeral	1 X Never Married 2 Married Armed Forces?	Yes, specify Cuban, Mexican, Puerto		White, etc.	- 1
her de	- 1	1 X Yes 2 No 3 Widowed 4 Divorced If Yes, Give Year 1	Yes 2 X No specify:		Specify: Whi	te
ours af	d by	15. Decedent's Education (Specify only highest grade completed)  16a. Decede	nt's Usual Occupation (Give kind of most of working life, DO NOT use reti		6b. Kind of Business/Ir	ndustry
72 ho	eg	Elementary/Secondary (0-12) College (1-4 or 5+)	-			
vithin ene.	Completed		hanical Engine		Westingh	ouse
Hygi d oth	ပ္တို	17. Father's Name (First, Middle, Last)		e (First, Middle, Mai		
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once	e Be	Nicholas Davidovic  19a. Informant's Name/Relationship (Type, Print ) 19b. Mailin	ng Address (Street and Number or	ha Burs	1 K r. City or Town, State,	Zip Code)
nore, MD 2 ages I and 2 shou int of Health and N it: If item 27 is n other traumatic						111
and and Health		20a. Method of Disposition 20b. Place of Dispo	Gold mine Roa	Date 2	0c. Location - City or	Town, State
DOF ages ] nt of ] other		1 XBurial 2 Cremation 3 Removal from State crematory or or Glen Hay	ven Cemetery 1	0-6-07	Glen Bur	nie MD.
Baltimore, permit. Pages I an Department of He Important: If ite	- 1					
in De la R		21. Signature of Funeral Service Licensee 22.  Mushael P. Maryaello 6.  23a. Part I. Enter the disease, or complications that caused the death. Do not enter	009 Harford Ro	ad Balt	imore, Ma	ryland2121
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter failure. List only one cause on each line.	the mode of dying, such as cardiac	or respiratory arrest	, shock, or heart	Detween Chock and
/Medical :xaminer		Immediate Cause (Final disease a. Atherosclerotic Cardiovascular Di	<b>se</b> ase	N		Death
		or condition resulting in death)  Due to (or as a consequence of):		* *		
	ē	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):				
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a- a	Physician/Medical	UNPENDED AMENDED				
Box 68760, e death certificate be the attending physicied for use as the burned for use	Med	IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of delivery	
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eath c atten for us	sic	1 Yes 2 No 9 Unknown 9 Unknown	Other (Specify)			
D. B t the d by the		Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did toba	acco use contribute to	the cause of death?
on of Vital Records, P.O. Box 68760, ending Physician: The law requires that the death certificate be ath an Anter this certificate has been signed by the attending physici he funeral director, page 2 should be detached for use as the buri	Completed by			1 Yes	2 No 3 Prot	ably 4 🗸 Unknown
of Vital Records, ng Physician: The law requir Nier this certificate has been s meral director, page 2 should t	etec			24a. Was an autopsy		topsy findings available completion of cause of
e law e has ge 2 sl	m d			perform	ed? death?	
Vital Reco ysician: The law his certificate has director, page 2 s		25. Was case referred to medical	26.Place of Death (Check		Language Company	
Vita hysicia this cel	o Be	examiner? 1 ✓ Yes 2 No  Hospital: 1 Inpatient 2 ER/Outpatie	nt 3 DOA Other Nursi	ng Home 5 Re	esidence 6 🗸 Other	: Scene
1 of Ving Phy After the	-	27. Manner of Death 28a. Date of Injury 28b. Time of	f Injury 28c. Injury at Work?	28d. Describe ho	w injury occurred	
ision Attendi r death ector: /	atio	1 V Natural 5 Pending 2 Accident Investigation	1 Yes 2 No	T = 1,2,		
	Certification:	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, str	eet, factory, office building, etc.	28f. Location (Str or Town, Sta		ral Route Number, City
ig 8 5 id	Cer	4 Homicide determined (Specify)			<del> </del>	
To the Hospital within 24 hours	ical	29a. Certifier (Check only one)    Certifying Physician: To the best of my knowledge, death occur (Check only one)    Wedical Examiner: On the basis of examination and/or investigned.	curred at the time, date and place, an pation, in my opinion, death occurred	d due to the cause( at the time, date ar	s) and manner as stat id place, and due to th	ed. e cause(s)
Som of an and	Medical	and manner stated.  29b. Signature and title of certifier	29c. License number		29d. Date signed (Mo	
		Daro X.	O.C.M.E.		September 9, 20	07
		30. Name and address of person who completed cause of death (Item 23a)				
10		A	Street, Baltimore, MD 2120	)1		
	tate	31. Date filed (Month, Day, Year) 32 Registrar's Signature	anti)			
Regis	ueli	00100000				

State Registrar 31. Date filed (Month, Day, Year) 2007 DHMH 17 Rev 1/2001 OCME 2006

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	п		Registrar  1. Decedent's Name (First, Middle, Last)		Cel		Dealli	2. Date of Dea	Reg. No. 2	U	32424 3. Time of Death
ľ	Physicia /Medic		DERRICK JAMES		Есн,	ARD		Month SEPTEM	Day	Year	12:01 PM
,	Examin	40	4a. Facility Name (If not institution, give street and nu	,		4b. City, Town, o	~	th	4c. County	of Death	
	25.		THE JOHNS HOPKINS HOSPI			BALTIMORE If Under 1 Year					
ľ	Funeral Director		5. Social Security Number 6. Sex 1₺ M 2☐ F	7. Age ( <i>In yrs.</i> 47	Yrs.	Months Days	If Under 24 Hr. Hours Min		r. Year)	Cour	lace (State or Foreign htry) hington,DC
	w		Usual Residence of Decedent  10a. State 10b. County	10c. City	y, Town or Lo	ocation				1	0d. Inside City Limits
	Maryla f sho ed at	ō	MD Anne Arundel	Edge	ewater						1 X Yes 2 No
	the P 28a-	rect	10e. Street and Number	павс	- Water	10f. Zip Code			10g. Citizen of V	What Cour	ntry?
	th with 23a or ust be	ral Di	1608 Marlboro Rd.			2103	37		U.S.A.		
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Married  1 □ Never Married 2 □ Married  1 □ Yes, Gi Year or E Year or E	2 <b>⊠</b> No ive		Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 ☑ No	lispanic Origin? ( an, Mexican, Pue Specify:	Specify Yes or No- rto Rican, etc.)	Blac	e - Americ ck, White, V: White	etc.
21215-0036	72 hou natura ical E	Completed	15. Decedent's Education (Specify only highest grade completed)		16a. Dece	dent's Usual Occup	ation	arkina .	16b. Kind of B	usiness/In	dustry
2	ithin 7 ne. nan "r	nple	Elementary/Secondary (0-12) College (			kind of work done DO NOT use retire		orking	0		
2	led wi tygier her th it, the	S	12		Shee	t Metal W		VEINA ARISTA	Constr		on 
Maryland	l be fi	Be	17. Father's Name (First, Middle, Last)					ame (First, Middle, Shelton		ne)	
Ĕ	hould of Me mark matic	ျှ	John W. Echard  19a. Informant's Name/Relationship (Type. Print)		19h Maili	ng Address (Street				State Zir	Code)
	nd 2 sulth an 27 is rtrau		Donna Echard/Sister		1608	Marlboro	Rd., E	dgewater,	MD 210	37	, Code)
ē,	s 1 ar		20a. Method of Disposition	20b. F	Place of Disponentery, cre	osition (Name of matory or other pla	ce)	Date	20c. Location -	City or To	own, State
<u>m</u>	Page nent c int: If		1 ☐ Buria! 2 ☑ Cremation 3 ☐ Removal from 4 ☐ Donation 5 ☐ Other (Specify)	State		oln Crem.		29/2007	Brentwo	od, M	ÍD.
Baltimore,	permit. Departn Importa any Inju		21. Signature of Funeral Service Licensee	Auler	2	2. Name and Addre	ess of Facility <b>F</b> t			MD 20	)722
			23a. Part1. Enter the disease, or complications that shock, or heart failure. List only one cause on	caused the deatl	h. Do not en	ter the mode of dyi	ng, such as cardi	ac or respiratory a	rest,		Approximate Interval Between
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Division or Vital Records, P.O. Box	The law requires that the death certifi ute has been signed by the attending bage 2 should be detached for use as	Physician/Me	23b. Was decedent pregnant 1 Live	utcome pf pregna birth 2 ☐ Feta Inant at time of d nown	al death 3[	⊒Ectopic pregnanc ⊒ Other <i>(specify)</i> _	у			te of delive onth	ery Day Year
σ.	that i		Part II. Other significant conditions contributing to contributing the contributing to contributing the contributing to contributing the contributing to contributing the contribut	death but not res	ulting in the u	ınderlying cause giv	ven in Part I.	23e. Did t	obacco use con	tribute to t	he cause of death?
rds	quires in sign	ed by						1 🗆 '	Yes 2 No	3 ☐ Prol	pably 4 ∏Unknown
Reco	The law re	Completed		·				24a. Was autoj perfo	rmed?		opsy findings available impletion of cause of
<u>ita</u>	i <b>ician:</b> Th certificate rector, pag	Be C	25. Was case referred to medical examiner?				26. Place of D	eath (Check only o	· ·	1 🗆 103	~~~
<u>7</u>	hysic his ce	To	1 ☐ Yes ZANo Hospital:		ER/Outpatie	IN SELDON		Home 5 ☐ Resi	dence 6 □Ott	ner (Speci	fy)
o LC	Attending Physician: r death. ector: After this certifics by the funeral director, p		Tantaturar 3 i ending	e of Injury nth, Day Year)	28b. Time o Injury	Wo		28d. Describe	now injury occur	red	
<u>sic</u>	ttend death ctor:	icat	2 Accident investigation 3 Suicide 6 Could not be 28e Plac	e of injury - At h	ome farm st	M 1 Treet, factory, office	Yes 2 □ No	29f Location /	Street and Num	har ar Pur	al Route Number,
<u>≥</u>	al or A after I Direct d in by	Certification:	4 Homicide determined build	ding, etc. (Specif	fy)	. 001, 140101 y, 011100		City or To	vn, State)	Jei oi Hui	ai riodie Namber,
	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the 2 Medical Examiner: On the and mar	e best of my kno basis of examina nner stated.	owledge, dea ation and/or in	th occurred at the tinvestigation, in my	ime, date and pla opinion, death oc	ce, and due to the curred at the time,	cause(s) and m date and place,	anner as s	stated. to the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier			29c. Licens	se number		29d. Date signe	ed (Month,	Day, Year)
			Hamilwowsh, MEDI	CAL DOCT	OR	RES	-000		SEPTEMBE	R 19	, 2007
1	- (3)		30. Name and address of person who completed cau JASON TURCWSKI, THE JOHNS HOPKIN				TREET, BALT	IMORE, MARY	LAND 2128	87	
	Sta Registi		JASON TUREWSKI, THE JOHNS HOPKING 31. Date filed (Month, Day, Year) SEP 2 5 2007	Registrar's Signa	pers	,	,				
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DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 20 32425 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician EVELAND** SEPT. 2007 8:20 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** MONTGOMERY VILLAGE HEALTH CARE CTR. GAITHERSBURG MONTGOMERY If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 6. Sex **Funeral** Months 1 ☐ M 2 🕱 F Director MAY 24, 1905 102 **NEW JERSEY** 138-54-8192 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits r than "natural", or Itema 23a or 28a-f ehow the Medical Examinar must be notified at 1**▼**Yes 2 No Director MONTGOMERY SILVER SPRING 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 14911 NEW HAMPSHIRE AVE. 20905 U.S.A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 72 hours after 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: 3 ₩ Widowed 4 Divorced WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry within Elementary/Secondary (0-12) College (1-4or 5+) 2 should be filed with and Mental Hygiene. 8 HOMEMAKER HOME marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ALFRED DELBARIO CATERINA **CASTILLO** 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 JOAN D. CADMUS/DAUGHTER 3700 SPRUELL DR., SILVER SPRING, MD. 20902 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1
Depertment of H
important: if Ite
eny Injury or ott 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CHAMBERS CREMATORY | 9-25-2007 RIVERDALE, MD. 22. Name and Address of Pacility
CHAMBERS FUNERAL HOME & CREMATORIUM, P.A M00091 5801 CLEVELAND AVE., RIVERDALE, MD. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** CORONARY ARTERY DISEASE /Medical Due to (or as a consequence of) Examiner HYPERTENSION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) death certificate be executed rsiclen and burial-trans ARTHRITIS Due to (or as a consequence of) physicien a HYPOTHYROIDISM Physician/Medical use as attending p IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Tetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day 4 Pregnant at time of death 5 Other (specify) ed by the a o 9 Unknown 9 Unknown ۵. s been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, δ 1 ☐ Yes 2 📉 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? certificate 1 ☐ Yes 2 ☐ No Division of Vital 2**X** No After this certification, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: ٩ 1 ☐ Yes 2 📉 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred Attending 1 Natural 5 Pending death. 1 Yes 2 No investigation 2 Accident within 24 hours after death To the Funeral Director: completely filled in by the i 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ō 29a Certifies Monthlying Physician: To the best of my knowledge death occurred at the time, date and place, and due to the causa(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2 SEPT. 24, 2007 D41162 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 19529 DOCTOR'S DR., GERMANTOWN, MD. 20874 VINU GANTI, M.D. 31. Date filed (Month, Day, Year) 32 egistrar's Signature State 2 5 2007 SEP Registrar

Mary ERICSON

Corec/6

Registrar DHMH 17 Rev 1/2001

State

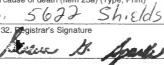
29a. Certifier (Check only one)

29b. Signature and title of certifier

Iruong

31. Date filed (Month, Day, Year) **SEP 26** 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



suc MD

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

Dr. Bethesda, Mb 20817

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#10b perFH C872 10/9/07 WS
State of Maryland Pepartment of Health and Mental Hygiens 7 32427 1 - State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month 2:20 A.M xline 28,200 Louise ettu September 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Hancock

If Under 1 Year If Under 24 Hrs.

Months Days Hours 1 13322 Exline Road ton 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 M 2 F 168-26-3004 Yrs. Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d, Inside City Limits Washington 1 TYAS 2 No tancock 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21750 USA 1332 Road Xline 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status ☐Yes 2XNo 1 Never Married 2 Married 1 Yes 2 No Specify If Yes, Give Year or Dates: Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Manag dees Kestaurant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Dec 19a. Informant's Name/Relationship (Type, Print, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Hancock MD 1tusband pralg 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Slate 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 10 Pring 22. Name and Address of acility arold M. Zimmerman & Son Funeral Home, 21. Signature of Funeral Service Licensee 45 South Carlisle Street, Greencastle, Approximate Interval Between Onset and Dean 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) perang Due to (or as a consequence of) Sequentially list conditions, if any, leading to initial discusse. Enter Underlying Cause (Disease or injury that initialed events resulting in death) Last Due to for as a consequence of Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? 2 🗆 No 3 Probably 4 Unknown ble of

**Physician** /Medical Examiner

Physician/Medical Examiner

Certification: To Be Completed by

Medical

**Physician** 

/Medical

Examiner

10a State

**Funeral** 

Director

s 23a or 28a-f show

permit. Pages 1 and 2 should be filed within 72 hours after deal Department of Health and Mental Hygiene. Imicratari: It itam 27 is marked other than "natural", or Items ? am - njury or other traumatic event, the Medical Exacultural and on...

Sultimore, Maryland 21215-0036

Directo

Be Completed by Funeral

the attending physician and hed for use as the burial-transit The law requires that the death certificate be executed P.O. Box 68760, detached Division of Vital Records, page 2 should hast certificate funeral director. After within 24 hours after death.

To the Funeral Director: A completely filled in by the fu ō

To the Hospital

9 Li Unknowh	
	tributing to death but not resulting in the underlying cause given in Part
. Drevious.	lung comes
locally re	current breast camce

26 Place of Death (Chi

24a. Was an autopsy performed?  Yes 2 No	24b. Were autopsy findings availa prior to completion of cause death? 1 ☐ Yes 2 ☐ No
ack anly anal	

25. Was case examiner?	referred to medical
1 Tes	≥√Z No
27. Manner of	eath

	1 Inpatient	2
ending	28a. Date of Injury (Month, Day Ye	ar)

2 🗆	ER/Outpatient	3□ DOA	Other: 4	☐ Nursing Home	5 Desidence	6 ☐Other (Specify)	
ar)	28b. Time of Injury		Injury at Work? 1  Yes	28	d. Describe how inj		

1 Natural 5 | Pe 2 Accident investigation 6 Could not be determined 3 Suicide 4 Homicide

		М	1
28 e.	Place of Injury - At home, farm, stre	et, factor	y, offi

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

🔀 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

29b. Sign	natþre	and	title	qf	certifier		
IK.			1	7	-		

29d. Date signed (Month, Day, Year, 400

Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Mo

Registrar's Signature

5

State Registrar

State of Maryland / Department of Health and Mental Hygier ho 0 ho 7 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) , 2. Date of Death 3. Time of Death **Physician** Month AROL LEE FISHER SEDT. 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 390 NORTH ShOKE RD. PASADENA ANNE ARUNDEL If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Months 1 M 2 F 219-42-1362 2 Director Usual Residence of Decedent with the Marylend 10a. State 10b. County 10c. City Town or Location 10d. Inside City Limits ?7 is marked other then "naturel", or Items 23e or 28e-f show traumetic event, the Madical Examiner must be notified at 1 ☐ Yes 2 ☐ No ANNE ARUND Funeral Director MD 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 390 North .5.A RO 2 filled within 72 hours aftar deeth 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: þ JAITE 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Pages 1 end 2 should be filed within nent of Health end Mental Hygiane. Int: if item 27 is marked other then " College (1-4or 5+) Elementary/Secondary (0-12) ECEPTIONIST 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) DEIBEL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 390 NOOTH STORE RD. PASADENA, M.D. Z1122 KICHARD E. FISHER, M.D. HUSBAND or other Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 □Removal from State permit. Page Depertment of Important: If eny injury or once. SENT CREMATORY \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fugeral Service Licenser 22. Name and Address of Facility Daugherty Family Funeral Home And Cremation Center, P.A. 2601 Mountain Road - Pasadena, MD, 21122 Part1. Enter the disea a caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Part1. Enter the disea of comples shock, or heart failure. List only Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Breast Carcinowa Physician metastatic /Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed signed by the attending physicien end d be detached for use as the burial-transit Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 → Yes 23d. Date of delivery 3 Ectopic pregnancy Year Month Day 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 Unknown been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy periorn this cartificete 2 No 1 ☐ Yes 2 ☐ No 1 Tyes or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 ZNo Other: Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ★ esidence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred : After 1 Natural
2 Accident 5 Pending death. investigation 1 ☐ Yes 2 ☐ No after death the 1 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours To the Funerel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) tranclina 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) ompleted cause of death (Item 23a) (Type, Print) ldman 31. Date filed (Menth, Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

			1 - For State Registrar	State of Maryl			of Healti of Deal			g. No.		0 2 1 2 3		
	Physici	200	1. Decedent's Name (First, Middle, Last						<ol><li>Date of Death Month</li></ol>	Day Year				
	Physici /Medic		Bartholomew J. F	ort					Sept. 2	24, 2007 9:20 A				
	Examir	er	4a. Facility Name (If not institution, give Bradford Oaks Nur	s <i>treet and n</i> um <i>ber)</i> sing & Rehat	'	4b. City, Town, or Location of Death Clinton			,	4c. County of Death Prince Georges				
	Funeral Director		5. Social Security Number 492–18–1330 6. Se	x 7. Age (in ) XM 2□F 89	yrs. last birthda Yrs.	y) If Under t Months	Year If Und Days Hour	der 24 Hrs. rs Min.	8. Date of Birth (Month, Day, Dec. 8,	1917	9. Birthpl Count Texa	ace (State or Foreign try) IS		
	pg &		Usual Residence of Decedent  10a. State 10b. County	10c	Location				10d. Inside 0					
	anyla eho	ō	MD Prince		Clinton	Location						1 ☐ Yes 2√CXNo		
vith the M	Director	10e. Street and Number 7520 Surratts Roa			10f. Zip 0	Code 07.35			g. Citizen of W	hat Coun				
Nore, Maryland 21215-0036 ges 1 and 2 should be filed within 72 hours after death with the Maryland at 04 Health and Mental Hygiene. If Item 27 ie marked other than "natural", or Items 23a or 28s-f show or other treumatic event, the Middeal Examinar must be notified at		by Funerai	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever i Armed Forces? XX Yes 2 ☐ No if Yes, Give Year or Dates:	in U.S. 13	3. Was Decede If Yes, specif			cify Yes or No- Rican, etc.)	14. Race Black	- America k, White, 6 Blac	etc.		
Maryland 21215-0036	within 72 ho ene. than "naturi ne Medical I	Completed	15. Decedent's Education (Specify only highest grade Elementary/Secondary (0-12)	cation (e completed) College (1-4or 5+)	16a. Dec (Gire	cedent's Usual ve kind of work DO NOT use	Occupation k done during n e retired)	nost of workin	19	6b. Kind of Bus	siness/Ind	lustry		
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Mary	and 2 should the salth and Menter in 27 le market ler treumatic		19a. Informant's Name/Relationship (7) Joan Fort - wife	vpe, Print)					Route Number, 410, He	-				
Baltimore,	Pages 1 and lent of Health nt: If Item 27 ry or other tr		20a. Method of Disposition 1 □ Burial 2 ☒ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify)	Removal from State	b. Place of Dis cemetery, ci [etropo]	rematory or oth	her place)	9/25		Oc. Location - 0				
Balti	permit. Pages: Department of h Important: If Ite eny injury or of		21. Signature of Funeral Service Licens	-		22. Name and 311 N .	Address of Fa Patric	ck St.	vis Fune Alexan	ral Hom dria, V	ne 7A 22	314		
	Physician /Medical		23a. Part Enter the disease, or composition of the	incations that caused the cause on each line.  a. Due to (or as a con	Derop				respiratory arres			Approximate Interval Between Onset and Death		
,760,	box box fou, death certificate be executed be ettending physician and d for use as the buriat-transit	d by Physician/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a con	sequence of):									
O. Box 68			IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pre 1 □ Live birth 2 □ I 4 □ Pregnant at time 9 □ Unknown	Fetal death 3	3 □Ectopic pre 5 □ Other (spe				23d. Date Mon	of delive	ry Day Year		
٥.	an the		ρ	ρ	Part II. Dther significant conditions co	ntributing to death but not	t resulting in the	underlying ca	use given in Pa	arf I.			bute to th	e cause of death?
Vital Records,	e h	Completed		perform	autopsy prior to completion of ca performed? death?									
<u> </u>		Be C	25. Was case referred to medical				26. P	ace of Death	eath (Check only one)					
<u> </u>	W 17	2	examiner? 1 🗆 Yes 🙎 No	Hospital: 1   Inpatient	2 ER/Outpat	ient 3 DO	A Other 4 5	Hursing Hon	lome 5 Residence 6 Other (Specify)					
Vision of Attending Physic death. ector: After this by the funeral diffication: To			27. Manner of Cath  1 Statural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Yea	28b. Time (r) Injury		2 ! 🗆 No	8d. Describe how	be how injury occurred					
Division	in all in	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					8f. Location (Street and Number or Rural Route Number, City or Town, State)					
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	To the comple	Me	29b. Signature and title of cataliar			7-29c	License numb	er	29	d. Date signed	( onth, l	Day, Year)		
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1	(5)		30. Name and .ddress erson who	mpleted cause of death  32. Registrar's S	(Item 23a) (Typ	e, Print)	701 /c	1 #/0	B 77.6	15 huy	tod	( NO) 20749		
	Sta Registi		3. Date filed (Month, Day, Year) SFP 2.5 2007	32. Registrar's S	ignature	L.						,		

riease	Type of Print in Black indelible ink. Ensure All Copies Are Legible.	
	State of Maryland / Department of Health and Mental Hygiene	0007

		1- For State Registrar			Ce	rtificate	of L	Death			Re	g. No.	Z <b>U</b> U	1 3	1243
Physici ledical Exam	an/	1. Decedent's Name (I		2. Date Mor Sep					Date of Death Month Day Year September 19, 2007			Death hrs			
		4a. Facility Name (if no Prince George		on, give street and number) ital				4b. City, Town, or Location of Death Cheverly				4c. County of Death Prince George's			
Funeral Director		5. Social Security Nun 213-42-909		. Sex	7. Age (In yrs. 61		Yrs.	If Under 1 Year Months Days		Adm	. Date of Birt		Forei	thplace (Sta WASHII) puntry) DC	te or NGTON
any same	<b>B</b> e trughe	Usual Residence of D				/, Town or Lo	cation	1							City Limits
4aryland 28a-f show Lat once.	Director	MD F 10e. Street and Numb		GEORGES	DI	STRICT		EIGHTS 10f. Zip Code			10	)g. Citizen o	f What Cou		2 No
i with the Maryland ms 23a or 28a-f sho be notified at once.		1773 ADDIS	SON RO.		cedent Ever in U	18 13	l seW	20747	panic Origi	n? (Specif		JSA 14 5	ace Amer	ican Indian,	Plank
b, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland tenth and Mental Hygies in the manual.", or items 23a or 28a-f She traumatic event, the Medical Exampler must be notified at once traumatic event, the Medical Exampler must be notified at once	by Funeral	3 Widowed 4 Divorced If Yes, Give Year or Dates:				1[	13. Was Decedent of Hispanic Origin? ( Specify N ff Yes, specify Cuban, Mexican, Puerto Rican,  1 Yes X No specify:				an, etc.)	Specify:BLAC			DIACK,
036 ithin 72 hour ene er than "natur dedical Exan	Completed	Elementary/Second		College (			g mos	Usual Occupati t of working life.				PRIVA	of Business	Industry	1.0
imore, MD 21215-0036 Pages I and 2 should be filed within 72 ment of Pleafin and Montal Hygiene faut: If item 27 is marked other frant or other traumatic event, the Medical or other traumatic event, the Medical	Be	JOSEPH F. FORD					RUTH HARPE				(First, Middle, Maiden Surname)				
MD 21 and 2 should safth and Me em 27 is ma raumatic ev	To	19a. Informant's Name  DENISE FOR  20a. Method of Dispose		HTER 17				SOUTH	ural Route Number, City or Town, SH DISTRICT HEIG  Date 20c. Location - Ci			HTS, MD 20747			
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ம் தித்தித் Physician	2 6	23a. Part I. Enter the o	Onlo	Constitutions that	2 caused the deat		474	4 LANDO	VER R	OAD L	ANDOV	ER, MD	2078	5	nate Interval
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of Vital Records, ng Physician: The law requir ther this certificate has been s meral director, page 2 should I	Completed										24a. Was autop perfor	sy med?		completion of	gs available of cause of
Vital Rec ysician: The his certificate director, page	Be	25. Was case referred examiner?		Hospital:	Inpatient 2	ER/Outpati	ent :		of Death (	Check only		Residence	6 Othe	er.	-
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Division pital or Attendii ours after death. eral Director: A	ertification:	2 V Accident 3 Suicide 4 Homicide  Investigation Sep 19, 2007   1837 hrs 28e. Place of Injury - At home, farm, street, f (Specify) Local Street						or Town, State)			tate)	et and Number or Rural Route Number, City ) nue, Seat Pleasant, Md.			
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	M	29b. Signature and title	e of certifier	May				29c. Licenso					ber 20, 2	onth, Day, Ye 2007	ar)
12 (5)		30. Name and address David Fowler		hief Medical E	Examiner	111 Penn		eet, Baltimor	e, MD 2	1201		•			
S Regis	tate trar	31. Date filed (Month, SEP 2 5	2007	Jewa 32. R	egistrar's Signa	Speck	,								
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OCME

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.? Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** SEPTEMBER 21, 2007 12:10P M WILKAAN FONG /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day 5. Social Security Number Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Nov. 18, 1924 Colorado 1 X M 2 □ F 523-22-2830 82 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must he notified at 10c. City, Town or Location 10h. County 10d. Inside City Limits MD Frederick Middletown 1 ☐ Yes 2 ☑ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6813 Southridge Way 21769 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1943 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. Afflied Folces: 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1946 1 ☐ Yes 2 No Specify: Chinese Specify þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) gov't scientist state 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be David H. Fong Wong Shee ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Henryetta Fong (Wife) 6813 Southridge Way, Middletown, MD 21769 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 □Removal from State □Donation 5 □ Other Reformed cemetery 9/29/07 Middletown, MD pecify) Fune VServio Donald B. Thompson Funeral Home P. O. Box 18, Middletown, MD 21769 21. Signature 23d. Part1. Enter the disease, or complice shock, of heart failure. List only one immediate cause (Final disease or condition resulting in death) Approximate Interval Between Oriset and Death that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Physician /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examiner The law requires that the death certificate be executed physician and s the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: for use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 5 Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by -OWER 2 No 3 Probably 4 □Unknown 1 Tyes certificate has been s rector, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1∐ Yes 2 No funeral director 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Hospital: 2 ►R/Outpatient 3 DOA Certification: To 1 Inpatient After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

Division or Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: filled in by

State

Medical

29a. Certifier

29b. Signatu

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated and title of certifier

29d. Date signed (Month, Day, Year)

person who completed cause of death (Item 23a) (Type

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#10e perFH C872 10/9/07 WS
State of Maryland Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** Samuel October 2, 2007 7:00 p James Faulkner, Jr. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 10920 Calvert Dumbarton Drive Dunkirk If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours 1X M 2□ F Director 579-36-1191 77 09-08-1930 Wash., D.C. Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Item 27 is marked other than "naturai", or Items 23a or 28a-f shov other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director MD Calvert Dunkirk 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code is 1 and 2 should be filed within 72 hours after death with in thealth and Mental Hygiene.
Item 27 is marked other than "natural", or Items 23a or? 10920 **Dumbarton Drive** 20754 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 XYes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 No Specify Specify: white þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 4 insurance agency insurance agent 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Samuel Faulkner, Evelyn Mae Winkelman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Barbara A. Faulkner, wife 10920 Dumbarton Drive, Dunkirk, MD 20754 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If Itel
any injury or ott 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Southern Mem. Gardens 10-5-2007 Dunkirk, MD 22. Name and Address of Facility Rausch Funeral Home, P.A. 21. Signature of Funeral Service Lic Willia 8325 Mt. Harmony Lane, Owings, MD 20736 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a conse me ce of): Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a conse uence of Examiner resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23h. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 2 **2** No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 Yes 2 No 2 ☐ Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

**Physician** /Medical Examiner anding physician and use as the burial-transit Box 68760. been signed by the a should be detached P.0. or Vital Records, this certificate has al director, page 2 To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director; After this certifica completely filled in by the funeral director, I **Division** To the Hospital or within 24 hours after To the Funeral Dis

28a-f show

3altimore, Maryland 21215-0036

State Registrar

(Check only one)

29b. Signature and title of certifie

and manner stated

29c. License number

29d. Date signed (Month, Day, Year)

Registrar's Signature

		State of Maryland / D	epartment of l Certificate of			ne N <b>2                                    </b>	221.22
5 4		Registrar  1. Decedent's Name (First, Middle, Last)	Certificate of	Death	Reg.	NoZ U U I	3. Time of Death
Physicia /Medica		Oscar Preston Fritz			Month	r 30 2007	6:40P M
Examine	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town,	or Location of Death		4c. County of Deat	
100000		Dove Hospice House  5. Social Security Number 6. Sex 7. Age (In yrs. last birt.		minster If Under 24 Hrs.	8. Date of Birth	Carr	
Funeral Director		1 MIN 00 5	rs. Months Days		Month, Day, Ye	ear) _ Co	thplace (State or Foreign ountry) ryland
The state age		Usual Residence of Decedent			Itali 14,	TOTO Ma	i y i aliu
ırylan thow	_	10a. State 10b. County 10c. City, Town	or Location				10d. Inside City Limits
e Ma Ba-f s	Director	Maryland Carroll	New Wi	ndsor			1 XYes 2 No
vith the		10e. Street and Number	10f. Zip Code		10g.	Citizen of What Co	ountry?
sath v	Funeral	2841 Carlisle Drive  11 Marital Status 12. Was Decedent Ever in U.S.	12 Man Decedent of I	21776	if- V N-	U.S.A	
ter do	Š	Armed Forces?  1 □ Never Married 2 Married 1 □ Yes 2 Mo	13. Was Decedent of I If Yes, specify Cub	pan, Mexican, Puerto	Rican, etc.)	Black, White	
urs al al", or Exam	2	If Yes, Give 3 Widowed 4 Divorced Year or Dates:	1 □ Yes <b>2</b> 1 □ No	Specify:		Specify: W	hite
15-UU36 172 hours af "natural", or	Completed	15. Decedent's Education 16a. (Specify only highest grade completed)	Decedent's Usual Occu	pation	ing 16b	. Kind of Business/	Industry
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and d be file ental Hy ced oth c event	Be	Oscar Phay Fritz			e (First, Middle, Maid	den Surname)	
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Mand 2 s allth an 27 ls i			341 Carlisl		New Windso		
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Page Page nent c		TEXBUILD 2 Colemation 3 Chemoval from State	eek Cemete	,	/2007 nr.	Linwood	. MD
Dallimore, IVI permit. Pages 1 and 2 Department of Health & Important: if Item 27 is any injury or other tra	- 1	21. Signification of Funeral Service Licensee	22. Name and Addre	ess of FacilityHart	zler Fune	eral Home	i anti-
D 99 F 99		affarine V. Harler	6 E. Broa		Jnion Brid		1791
· 4 - 57		23a. Part1. Enter the disease, or complications that caused the death. Do no shock, or heart failure. List only one cause on each line.	ot enter the mode of dyi	ng, such as cardiac	or respiratory arrest,		Approximate Interval Between
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/Medical Examiner		Due to (or as a consequence of AORTIC STE.					
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d uted	Examiner	If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events					
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The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	<u> </u>	d					
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ath cer attendin for use	an	23b. Was decedent pregnant in the past 12 months? 1□Live birth 2□Fetal death	3 Ectopic pregnanc	y		23d. Date of deli	ivery Day Year
the de	Pnysician/Me	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 9 ☐ Unknown	5 ☐ Other (specify) _				24,
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The I	E				autopsy performed 1⊟ Yes 2 🗷	? death?	completion of cause of 2 ☐ No
ilan: ]	De C	25. Was case referred to medical examiner?		26. Place of Death	Check onl one	ano i les	2 110
Physic certail direction	0	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Impatient 2 ☐ ER/Out			me 5 Residence	6 🗷 Other (Spec	city) HOSPICE
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Direct A Lin by	Certification:	4 Homicide determined building, etc. (Specify)	n, street, factory, office		28f. Location (Street City or Town, St		irai Houte Number,
spita nours neral	2	29a. Certifier Certifying Physician: To the best of my knowledge,	death occurred at the ti	ime, date and place,	and due to the cause	e(s) and manner as	stated.
To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as in the funeral director.	edical	(Check only 2 Medical Examiner: On the basis of examination and one)	or investigation, in my	opinion, death occur	red at the time, date	and place, and due	to the cause(s)
To th	M	29b. Signature and title of certifier	29c. Licens	se number	29d.	Date signed (Monti	h, Day, Year)
		Mm & Linthreson, MD	10014	1317	De	Toley 1,	2007
8		29b. Signature and title of certifier   MM C Lindhuch, MD  30. Name and address of person who completed cause of death (Item 23a) (T  WILLIAM R. LINTHICHM MD  31. Date filed (Month, Day, Year)  OCT 0 9 2007  Registrar's Signature	ype, Print)	DRIVE. 7	ANEYTOU	DN.mD =	21787
State Registra	e	31. Date filed (Month, Day, Year) 2007 Registrar's Signature	porte	1 /	,		
riegistia							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day 23, 2007 8:02 P William Ernest Gasch Sept. 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Montgomery 3128 Gracefield Road, Apt 122 Silver Spring If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Yea 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 1 M M 2 □ F 7. Age (In vrs. last birthday) Days Months 1934 Washington, DC July 1, 217-34-0018 73 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 21 No

10f. Zip Code

20904

10g. Citizen of What Country?

USA

Silver Spring

filed within 72 hours after death with the Maryland r 28a-f show notified at "natural", or items 23a or 3altimore, Maryland 21215-0036 the Medical and Mental Hygiene. traumatic event, permit. Pages 1 and 2 should be file Department of Heatth and Mental Hy Important: If Item 27 is marked othe any injury or other traumatic event, once.

**Physician** 

/Medical

Examiner

10a. State

10e. Street and Number

Maryland | Montgomery

3128 Gracefield Road, Apt 122

Director

**Funeral** 

Director

**Physician** /Medical Examiner

requires that the death certificate be executed and burial-trar physician the as attending property for use as ed by the a detached i signed by the sign of the sign cate has been si , page 2 should t certificate |

P.O. Box 68760,

Division or Vital Records,

After this funeral ospital or Attending hours a er death. ineral Director:

To the Ho	within 24 To the Fu completel
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Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Married White 1 ☐ Yes 2 🖾 No Specify à 3 ☐ Widowed 4 ☑ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Gasch's Funeral College (1-4or 5+) Elementary/Secondary (0-12) Funeral Director Home, P.A. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ruth Elizabeth Duley William Francis Gasch 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Claudette Gasch Lanning-Daughter 410 Whitestone Rd., Silver Spring, MD 20901 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Fort Lincoln Cemetery 9/27/2007 Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 4739 Baltimore Ave. Gasch's Funeral Home, P.A. Hyattsville, MD 20781 Con 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Hour Cerebrovascular Accident disease or condition resulting in death) Due to (or as a consequence of): Chronic Obstructive Pulmonary Disease 20 Years Sequentially list conditions, ir any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). ner Exami Due to (or as a consequence of): Physician/Medical IF FEMALE: 23d. Date of delivery 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 2 Fetal death 3 ☐ Ectopic pregnancy 1 ☐Live birth Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 X Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) Hospital: 11 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 2 28a. Date of injury (Month, Day Year) 28h. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: Injury 1 XNatural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Excertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of D24093 9/24/2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mark Parkhurst, MD 3110 Gracefield Road, Silver Spring, MD 32. Registrar's Signatu 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

SEP 2 5 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** B 0115 WATTUR GUZELSKY Sept 23 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BAIL, more NA 5. Social Security Number MANJANZ 6. Dex Center ecreal If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth Month, Day, Year) July 14, 1921 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** MD (Country) 1 M 28 F 86 Director 214-18-2043 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10a. State 10b. Count 10d. Inside City Limits 1X Yes 2 No Funeral Director FL Palm Beach Boca Raton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 250 South Ocean Boulevard, #16A 33432 US 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. Yes 2½ No f Yes, Give rear or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 No þ Specify: 3

Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 College (1-4or 5+) Business Executive Real Estate 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ္ Israel Berger Tillie Blumenstein 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Potomac, MD 20854 John Gudelsky-Son 9112 River Road 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☑ Removal from State King David Mem. Grdns. 09/24/2007 4 ☐ Donation 5 ☐ Other (Specify) Falls Church, VA 22. Name and Address of Facility Danzansky-Goldberg Memorial Chapels, Inc. 1170 Rockville Pike Rockville, MD 20854 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** CAEDIONIONETH 10 years /Medical Due to (or as a consequence of): Examiner Aust.c Stenosis years Sequentially list conditions, if any, leading to immediate cause. Observed or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by LEAST 24b. Were autopsy findings available prior to completion of cause of 24a. Was an CORONS autopsy performe Yes 2 death? certificate 2 □ No Yes 25. Was case referred to medical 26. Place of Death (Check only one examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Medical Certification: To 2 ☐ ER/Outpatient 3 ☐ DOA 1 Inpatient After this Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No Director: 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours are.

To the Funeral Dir Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) NPI 1598967499

State Registrar

DHMH 17 Rev 1/2001

2 5 2007

ERIC

31. Date filed (Month, Day, Year)

**ORIGINAL** 

Care

Street Birltineone

MO

2/201

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

South

Registrar's Signature

MO

COX

State of Maryland / Department of Health and Mental Hygien2007For State Registrer Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2007 Month Year **Physician** Linda Frame 26, Sept. 3:30 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Garrett County Memorial Hospital 0akland Garrett 8. Date of Birth (Month, Day, Year) Mar. 20, 1940 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral Min. 1 □ M 2 🛣 F Hours West Virginia 67 233-64-8034 Director Usual Residence of Decedent death with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d, Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Marylan ment of Health and Mental Hygiene. ant: If Itam 27 is marked other than "natural", or items 23s or 28s-f show ury or other traumetic event, the Madical Examines must be notified at 1 XYes 2 ☐ No Directo MD Garrett 0akland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Glades Square, #4 21550 **IISA** Funerai 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ģ If Yes, Give Year or Dates: 1 ☐ Yes 2 X No Specify: Specify: White 3 N Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) School Teacher Elementary Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be James Cumberford Frame, Sr. Dorothy Pear1 Edwards 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jennifer L. Sweitzer/ Daughter 603 Oak St., Mountain Lake Park, MD 21550 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If Ita
any injury or ot
once. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Garrett Co. Mem. Gds. 9/29/07 \* 4 ☐ Donation 5 ☐ Other (Specify) Oakland, MD 21. Signature of Funeral Services icense 22. Name and Address of Facility 32 S. Second St. Stewart Funeral Home 21550 Oakland, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician minutes Severe Aspiration-Terminal /Medical Due to (or as a consequence of) **Examiner** Severe Achalasia hours Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Day 5 Other (specify) 1 ☐ Yes 2 💹 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≥ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? has le 2 autopsy performed? page this certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2X No or Attanding Physician: director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ို 1 XYes 2 No 2 ☑ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation М Director: / 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours aff To the Funerel Di completely filled in 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) To the ! 29b. Signature and title of certifu 29c. License number 29d. Date signed (Month, Day, Year) D23979 09/28/2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Robert Goralski, MD 311 N Fourth Street 21550 Oakland, MD

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

Registrar's Signature

2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day 242007 **Physician** 0 001 thes /Medical 4a. Facility Name (If not institution, give street and number Town, or Location of Death County of Death **Examiner** Wicimico ledical Center Mesburg eninsula egIONA1 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days 1**№**M 2□F Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director Com ACTAN CCU 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 23442 Funeral Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: þ 3 ₩Widowed 4 □ Divorced lack Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "any Injury or other traumatic everit, the Mei Elementary/Secondary (0-12) College (1-4or 5+) JOA NOFKER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) C 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City of Town, State, Zip Code) Marlene /cmpcrance ville, UA, 23442 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) in Conctary 9-29-0) Temperateville, UA.
22. Name and Address of acility Remain mith Functor Home 21. Signature - Funeral Service Licenses O.BOX331 POCOMUKO City, md. 2185 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** failure Congestive /Medical Due to (or as Consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine death certificate be executed burial-trer Due to (or as a consequence of): Box 68760 attending physician Physician/Medical as the IF FEMALE: for use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. the 9☐Unknown 9 Unknown signed by t I be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 Yes 2 No 3 Probably 4 Unknown cate has been sig , page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy
performed Division or Vital 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Hospital: 27 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 12 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 28a. Date of Injury (Month, Day Year) To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral 27. Magner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 🗖 Natural 5 Pending investigation 1 Yes 2 No 2 Accident 6 ☐ Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 09,24,07 mD D41721 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BAZ 21804

DHMH 17 Rev 1/2001

State

Registrar

STEPHAN

31. Date filed (Month, Day, Year)

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5 ALISBURY

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400 E. SHORE DR

32. Begistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** William Mason George September 24, 2007 /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Rockville Montgomery Sunrise Assisted Living If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Social Securify Number 6. Sex **Funeral** Months 1 ☑ M 2 ☐ F 06/27/1927 Michigan Director 386-30-3275 80 Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1√∑Yes 2 No Director Maryland Montgomery Germantown 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20874 United States 13601 Spinning Wheel Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1∑Yes 2□No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No þ 3 Midowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) United States Depart-I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) of Defense Economist permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygic Important: If item 27 is marked other I any injury or other traumatic event, <u>tr</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mildred Phoebe Mason Henry George III ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type. Print) 13601 Spinning Wheel Dr. Germantown, MD 20874 Mary George / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 9-29-2007 Potomac, MD Gabriel Cemetery 22. Name and Address of Facility Joseph Gawler's Sons Inc. 21. Signature of Foneral Service Licensee 5130 Wisconsin Ave. NW Washington, DC 20016 23a. Part1. Enter the disease, or cor blications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List or one cause on each line. Approximate Interval Between Onset and Death 4 Years Immediate Cause (Final Advanced Dementia **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner requires that the death certificate be executed and burial-tran P.O. Box 68760, Due to (or as a consequence of) physician Physician/Medical the as attending p 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy 1 ☐ Live birth 2 ☐ Fetal death Month Day in the past 12 months? 5 Other (specify) 4☐Pregnant at time of death ☐Yes 2☐No the 9 ☐ Unknown þ 23e. Did tobacco use contribute to the cause of death? signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, \$ 1 Yes 2X No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 XNo page 2 s certificate has 1∏ Yes Physician: 25. Was case referred to medical examiner? 26. Place of Death Check onl one director, Be Other: 3□ DOA 4X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2[XNo 1 Inpatient 2 ER/Outpatient 1 ☐ Yes 2 this funeral 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury 28c. 27. Manner of Death Injury at Work? Hospital or Attending Pl 24 hours after death. Funeral Director; After t After t Certification: (Month, Day Year) Injury 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 ☐ Homicide To the Hospital within 24 hours a To the Funeral C 1 Kertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

State Registrar

DHMH 17 Rev 1/2001

completely

Medical

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

SEP

25

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2007

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D0061382

29d. Date signed (Month, Day, Year)

Sept. 24, 2007

			1- For State of Maryland / De Registrar		rtment of H		and Me	ental Hy	/giene Reg. No.	200	7	32439	7
			Decedent's Name (First, Middle, Last)	-				2. Date of D	eath		3	3. Time of Death	_
Н	Physici /Medic		Donald James Goletz, Sr.					Month Septem	ber 2	Year 2 <b>4,</b> 200		7:15 P M	
	Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location o				County of De	ath		_
			Suburban Hospital	$\rightarrow$	Bethesda		2411-			ntgomen			
В	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birtho	* '	If Under 1 Year Months Days	Hours	Min.	8. Date of Bi (Month, D	ay, Year)		Country)	e (State or Foreign	7
			206-32-8524 66 TR					Jan 16	, 194	41 Per	nnsy	1vania	_
	ryland how		10a. State 10b. County 10c. City, Town of	r Loca	ation						10d.	Inside City Limits	
	e Ma Ba-f s	Director	MD Montgomery Beallsv:	i11	.e							1 ☐ Yes 2X No	
	a or 2	Dire	10e. Street and Number		10f. Zip Code					zen of What C	Country	?	
	is 23s	eral	18900 Beallsville Road  11 Marital Status 12. Was Decedent Ever in U.S.	12 \	20839	on anio Osia	ria? (Casa	ih. Van av bl	USA	14. Race - Am	noriona	Indian	_
	r iter	Funeral	Armed Forces?	lf.	as Decedent of His Yes, specify Cubar	n, Mexican	, Puerto F	ican, etc.)	0-	Black, Wh			
8	ours a rai", o Exam	ρ	1 □ Never Married 2 □ Married 1 ☒ Yes 2 □ No If Yes, Give Year or Dates: 1958–62	1[	☐ Yes 2☐XNo	Specify:				Specify: Wh	nite	:	
2	be filed within 72 hours after death with the Maryland that Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Completed	15. Decedent's Education 16a. D (Specify only highest grade completed) ((	ecede Give k	ent's Usual Occupa	ition Jurina most	of workin	a	16b. Kii	nd of Busines			
2	vithin ne. han " Me	du	Elementary/Secondary (0-12) College (1-4or 5+)	fe. Do	aind of work done d O NOT use retired;	)					_		
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an	0 7 9	To Be	Edward John Goletz, Sr.					Dresm		Sumanie)			
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Ž	and 2 alth a 27 is		Lisa Yazdani/daughter 108	18	Pinev Me	eting	house	e Rd.	Potor	mac. MI	20	854	
ore.	of He fitem		20a, Method of Disposition 20b, Place of D	isogsi(		- 10		ite		cation - City o			_
Ĕ	Pag ment ant: I		4 Donation 5 Other (Specify) Chesape	ake	Cremato	ry 0	9/26	/07	Belts	sville,	, MD	)	
Baltimore,	permit. Page Department of Important: If any Injury or once.		21. Signature of Funeral Service Ucenset	22. Go	Name and Addres	s of Facility Crem	atio	n Serv	rice	P.O. I	Вох	784	
	a o		MO1251	Be	verly L.	Heck	rotte	-, P.Δ	. C1:		lle.	MD 2102	2
			23a. Part1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line. Immediate Cause (Final	enter	r the mode of dying	g, such as	cardiac or	respiratory	arrest,		Init	proximate terval Between nset and Death	
	Physician /Medical		disease or condition resulting in death) a.	en									_
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		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	:							6		_
	cuted nd ransit	Examiner	that initiated events c.								Ì		
Ď,	e exe ian ar urlal-t		resulting in death) Last Due to (or as a consequence of)	:									
8760	icate be executed physician and sthe burlal-transit	dical	d								-		
9 ×	death certific attending p	/Med	IF FEMALE:										-
ROX	The law requires that the death certific tle has been signed by the attending f rage 2 should be detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?  1 Very 2 Very 1 Very 2 Very		Ectopic pregnancy Other (specify)				2	23d. Date of d Month	elivery Da	y Year	
o i	s that the de ned by the a detached t	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 ☐ Unknown	<u>о</u> П.	Other (specify)								
7. J	s that ned b		Part II. Other significant conditions contributing to death but not resulting in the	ne uno	derlying cause give	n in Part I.		23e. Did	tobacco u	se contribute	to the c	ause of death?	
<b>Records</b> ,	w requires been sign should be	ed by						1 🗆	Yes 2[	□ No 3 □ I	Probabl	y 4 Unknown	ı
ပ္ပ	law re	plet						24a. Wa		24b. Were	autopsy	findings available	<del>-</del>
		Completed							opsy formed? 2 \texts No	death?	? .	etion of cause of ☐ No	
VITal	Physician: The law this certificate has l ral director, page 2 s	Be	25. Was case referred to medical examiner?			26. Place	of Death	(Check only					_
0	this ald	은	1 ☐ Yes 2 No Hospital: 1 Inpatient 2 ☐ ER/Outpa			4 L. Nui				6 □Other (Sp	ecify)		
	ding F h. After funera	ion:	27. Manner of Death 1 ☑Natural 5 ☐ Pending (Month, Day Year) 28b. Tim		28c. Injury Work			3d. Describe	how injur	y occurred			
UIVISION	Attendideath.	icat	2 Accident investigation 3 Suicide 6 Could not be determined determined	stre		/es 2□N		of Location	(Stroot on	d Number or I	Pural P	auta Number	
<u>≥</u>	after after Dire	Certification:	4 ☐ Homicide determined building, etc. (Specify)	, 000	or, rectory, ornoc		-		own, State		nuiai N	oale ivamber,	
	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the fune		29a. Certifier 1 Certifying Physician: To the best of my knowledge, or	leath	occurred at the tim	ne, date an	d place, a	nd due to the	e cause(s)	and manner	as state	ed.	_
	he Ho in 24 I he Fu pletel	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/one and manner stated.	or inve	estigation, in my op	oinion, dea	th occurre	d at the time	e, date and	I place, and d	ue to th	e cause(s)	
	To t To t	Σ	29b. Signature and title of certifier		29c. License				29d. Dat	e signed (Moi	nth, Daj	y, Year)	
7			Micha			276			9	125/2	500	7	
9	E		30. Name and address of person who completed cause of death (Item 23a) (Ty	/pe, P	Print)	RI	RI	0.1-	MAA				
-/	Sta	to	STEVEN WILKS M.D. 8 600 Old ( 31. Date filed (Month, Day, Year) 32. Resistrar's Signature	20	FYETOWN	10	Dell	resda,	141)	20814			_
	Registr		30. Name and address of person who completed cause of death (Item 23a) (Ty Steven Wilks M.D., 8 600 01d) (31. Date filed (Month, Day, Year) 32. Peistrar's Signature SEP 2 6 2007	1	meter								

DHMH 17 Rev 1/2001

COLETZ

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Month **Physician** 1:00 AM M September 22 2007 Sarah Elizabeth Graves /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Fadlity Name (If not institution, give street and number) **Examiner** Charles La Plata La Plata Center Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Social Security Number 6. Sex **Funeral** Months 1 □ M 2√2 F 86 1921 TN 413-62-0426 Director Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10c. City, Town or Location 10a, State 10b. County "natural", or items 23a or 28a-f show dical Examiner must be notified at 1 ☐ Yes 2 TNo Charles Indian Head Funeral Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20640 3805 Marvin Drive USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 █️No If Yes, Give Year or Dates: 14. Race - American Indian Black, White, etc. 11 Marital Status filed within 72 hours after 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🔀 No Specify: Baltimore, Maryland 21215-0036 Specify: White þ 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) event, the Medical (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Laborer Bakery marked other 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy, Important: If item 27 is marked othe any Injury or other traumatic event, once. 17. Father's Name (First, Middle, Last) Be Lee Parker Elizabeth James ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3805 Marvin Drive, Indian Head, MD 20640 Donna Aheron/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Pleasant Grove Cem. 9/26/07 Maryville,TN 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility AREHART-ECHOLS FUNERAL HOME, P.A. 211 St. Mary's Ave. La Plata, MD Approximate Interval Between Onset and Death 1 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one race on each line. Immediate Cause (Final disease or condition resulting in death) 260821220 wa **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentiall, list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence or). Examiner requires that the death certificate be executed and burial-tran Due to (or as a consequence of): Box 68760, physician Physician/Medical the attending IF FEMALE: asn 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year for in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown 4☐Pregnant at time of death 5 ☐ Other (specify) P.0. ed by the a detached f 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, Ď 2No 3 Probably 4 Unknown page 2 should Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No certificate has 1□ Yes Physician: 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Other: 2X No 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 🗌 Yes 1 🔲 Inpatient 2 ER/Outpatient 3 DOA P this funeral 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: After Injury Natural (Month, Day Year) 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No ne Hospital or Attendi n 24 hours after death. The Funeral Director: A pletely filled in by the fo death. 2 ☐ Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 29d. Date signed (Month, Day, Year) 29b. Signat and title of certifie person who completed cause of death (Item 23a) (Type, Pri re and address of WALDGRY-NATHE TEOR 6 32. Pagistrar's Signature 31. Date filed (Month, Day, Year) State 2007 Registrar SEP

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			State	State of Mai		artment of ertificate of		d Mental Hy			
			Registrar  1. Decedent's Name (First, Middle, Last)			Tillicate of	Dealli	2. Date of De	Reg. No. 2	007	32441
	Physicia		Grace		Hi	11		Month Septeml	Day	Year	3:53 P M
	/Medic Examin		4a. Facility Name (If not institution, give st	reet and number)	11.1.	4b. City, Town,	or Location of E			ity of Death	3.55 1
<i>)</i>	LXdiiiii	Ç.	908 Lake Front Dr	ive		Mitchel	lville		Princ	e Geo	rge's
***	Funeral		Social Security Number     6. Sex		(In yrs. last birthday	Months Days		Hrs. 8. Date of Birl Min. (Month, Da	h v. Year)	9. Birthp	lace (State or Foreign
	Director		5/7-96-4903	M 2⊠F	72 Yrs.	Jay C	Tiodio .	July 2	9 1935		ington,DC
	and w	-	Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or I	ocation.				1	0d. Inside City Limits
	Maryl f sho fed al	ō	Md Prince Ge		Mitchel:	1					1y⊒Yes 2 No
	the t	Director	10e. Street and Number	orge s	MILCHEI.	10f. Zip Code			10g. Citizen o	of What Cour	ntry?
	h with	<u>=</u>	908 LAKE Front Dr	ive		20721			U.S	S.A.	
	deat	Funeral		2. Was Decedent Ev Armed Forces?	er in U.S. 13		Hispanic Origin	? (Specify Yes or No Puerto Rican, etc.)		ace - Americ	
9	within 72 hours atter death with the Maryland ene. than "natural", or items 23a or 28a-f show he Medical Examiner must be notified at	Fu	1 ☐ Never Married 2 ☒ Married	1 ☐ Yes 2 🔀 No		1 ☐ Yes 2 ☑ No		dello filoari, etc.)	Spec	12	lack
80	urai", il Exa	d by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:	100						
5	"nat	Completed	15. Decedent's Educa (Specify only highest grade	completed)	(Giv	edent's Usual Occu re kind of work done DO NOT use retire	upation e during most of ed)	f working	16b. Kind of	Business/In	dustry
7	withi ene. than than	шс	Elementary/Secondary (0-12) 12th	College (1-4or 5+	)	ay Care I			Pr	ivate	
D	be filed within 72 hours atter death with the Marylar ital Hygiene. ed other than "natural", or items 23a or 28a-f show other than "natural", or items 23a or outfled at event, the Medical Examiner must be notified at	Be C	17. Father's Name (First, Middle, Last)			uy ourc r		Name (First, Middle,			
Jan	should be f and Mental I s marked of umatic eve	To B	Theodore Bowlding				Juani	ta Pope			
Maryland 21215-0036	12 should be n and Mental ' is marked o raumatic eve	1.5	19a. Informant's Name/Relationship (Typ	,	I .	-		or Rural Route Numb			,
Σ,	and 2 ealth n 27 i	133	George A. Hill/Husl	band				e Mitchell			
ore	ges 1		20a. Method of Disposition  1	moval from State	20b. Place of Disp cemetery, cr	oosition (Name of ematory or other pl	ace)	Date	20c. Locatio	n - City or To	own, State
Ë	Emenition transfer tr	1	4 Donation 5 ☐ Other (Specify)			Cemetery			Landov		
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: if item 27 is marked any injury or other traumatic es once.		21. Signature of Funeral Service Licenser	Varial		22. Name and Add		J. B.Jen Road Lando			
			23a. Part1. Enter the disease, or complic	eations that caused t	he death. Do not e	· ·			***	ryrand	
g =	Physician	8 1	shock, or heart failure. List only one Immediate Cause (Final disease or condition		CLEROTIC	CARDTOVA	SCIII.AR	DISEASE		1	Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)		consequence of):						
	Examine	<u>.</u>	Sequentially list conditions, b.	Do b from							
-	red Isit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Day to for de a	concequence of):						
_ E	execur and al-trar	Examiner	that initiated events c. resulting in death) Last	Due to (or as a	consequence of):						
8760	the death certificate be executed y the attending physician and iched for use as the burial-transit	dical E	d								
9	tificat ig phy as th	ledi							- 1		
Вох	leath certific attending p	N/us	23b. was decedent pregnant	3c. If yes, outcome p 1□Live birth 2		□Ectopic pregnan	rcv			Date of deliv	*
	ed for	sicis	in the past 12 months? 1 ☐ Yes 2 🛣 No	4□Pregnant at t		Other (specify)				Month	Day Year
P.0	that the de red by the detached	Physician/Me	9 ☐ Unknown  Part II. Other significant conditions cont		not reculting in the	underheing course of	iven in Dect I	220 Did t	obacco use o	ontributo to t	he cause of death?
Š,	Se Les	þ	DIABETES MELLITUS,			underlying cause g	nven in raiti.	1 🗆			bably 4 □Unknown
Vital Records,	w requir been si should b	Completed	SPINAL STENOSIS, C						Λ.		
Bec	has ge 2 s	ld III						— 24a. Was auto		prior to co death?	opsy findings available empletion of cause of
a			25 Was case referred to medical				00 50	1□ Yes	2 No	1 ☐ Yes	<b>2</b> € No
	5 8 9 9 P	o Be	25. Was case referred to medical examiner?  1 Yes 2 XNo	ospital:	t 2 ☐ ER/Outpati	ent 3 DOA	thor	f Death <i>(Check only o</i> ing Home 5 🔼 Resi		Othor (Coori	
0		-	27. Manner of Death	28a. Date of Injury	28b. Time	of 28c. Inj		28d. Describe			ry)
ion	Attending r death. ector: After by the fune	atio	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day	Year) Injury		ork? ⊒Yes 2⊒No				
Division	i or Attendafter death Director:	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injur building, etc.	y - At home, farm, (Specify)	street, factory, office	9	28f. Location ( City or To		mber or Run	al Route Number,
	ital or irs afte rai Dir lled in	Se	T.	<u> </u>							
	Hospital	ical	29a. Certifier 1 ☐ Certifying Phys (Check only one)  1 ☐ Certifying Phys 2 ☐ Medical Examin	er: On the basis of	examination and/or	ath occurred at the investigation, in my	time, date and y opinion, death	place, and due to the occurred at the time.	cause(s) and date and place	manner as s ce, and due t	stated. to the cause(s)
	To the Hospital or Atti within 24 hours after de To the Funeral Directi completely filled in by t	Medical	29b. Signature and title of certifier	and manner stat	A.	29c. Lice	nse number		29d. Date sig	ned (Month.	Day, Year)
	FBF8		> 11. Servi	ans	ndar	DEG	267				
. 1	(2)		30. Name and address of person who con		ath (Item 23a) (Tvp	D53	30/		Septen	noer 1	8, 2007
1			Shyamsundar Rajan		, , , , , ,		#_117_S	ilver Spr	ing,Mar	yland	20902
	Sta	ite	31. Date filed (Month, Day, Year)	32. Registra		,					

Physician /Medical **Examiner** 

filed within 72 hours after

Baltimore, Maryland 21215-0036

or Attending Physician: The law requires that the death certificate be executed

After

after death

To the Hospital o within 24 hours aft To the Funeral D

in by t

Division or Vital Records. P.O. Box 68760

Completed by Be 2

Certification:

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? 1□ Yes 2□ No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 💢 No 1 🗌 Inpatient 2X ER/Outpatient 3 □ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

29c. License number

M.D.11355

29d. Date signed (Month, Day, Year)

9/24/2007

31. Date filed (Month, Day, Year) State 2007 Registrar

29b. Signature and title of certifier

32. Registrar's Signature

BRUCE COOPER, M.D. 1011 NORTH CAPITOL ST, N.E. WASH., D.C. 20002

30. Name and address of person who completed course of death (Item 23a) (Type, Print)

07-0720	)5	
	_	

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

ugene F. Hiers		ertificate of Death	Reg. No. 2007 3244
Physician/ ledical Examiner	Decedent's Name (First, Middle,Last)     Fugene P. Hiers		2. Date of Death
	4a. Facility Name (if not institution, give street and number) 7733 Oxman Road	4b. City, Town, or Location of Death Landover	<u></u>
Funeral Director	577–50–1870 1 <sub>X</sub> M 2 F	s. last birthday)  If Under 1 Year  Months  Days  Hours  Min	8. Date of Birth (MW/DD/YYYY) 9. Birthplace (State or Foreign Country) 1, 1936 Carolina
nd how any ce.	Usual Residence of Decedent  10a. State  10b. County  Manyland  Prince George's	ity, Town or Location Landover	10d. Inside City Limits 1 X Yes 2 No
th the Maryland 23a or 28a-f show notified at once. al Director	10e. Street and Number . 7733 Oxon Road	10f. Zip Code 20785	10g. Citizen of What Country?
er death with	11. Marital Status  1 X Never Married 2 Married Armed Forces?  1 Yes 2 X No  3 Widowed 4 Divorced If Yes, Give Year	If Yes, specify Cuban, Mexican, Puerto	
21215-0036 Ould be filed within 72 hours after death with the Maryland I Mental Hygiene in marked other than "natural", or items 23a or 28a-f shi ic event, the Medical Examiner must be uotified at once To-Be Completed by Funeral Director	3 Widowed 4 Divorced If Yes, Give Year Lor Dates:  15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  12th grade  College (1-4 or 5+)		work done 16b. Kind of Business/Industry
21215-0036 uld be filed within 72 hour Mental Hygiene marked other than "natter event, the Medical Exal ForBe Completed	17. Father's Name (First, Middle, Last)		e (First, Middle, Maiden Surname)
MD 2121. d 2 should be fifth and Mental I in 27 is marked aumatic event, To: Be	Bernard Hiers, Sr.  19a. Informant's Name/Relationship (Type, Print)  Shorone E. Lee (Sister)	19b. Mailing Address (Street and Number or. 1836 Village Green Drive	Alma Pauls Rural Route Number, City or Town, State, Zip Code) Landover, Marvland 20785
Baltimore, MD 21215-0036 pennit. Pages 1 and 2 should be filed within 72 hou Department of Health and Mental Hygiene Important: If item 77 is marked other than "nati injury or other traumatic event, the Medical Exa To: Be Completed	20a Method of Disposition 20	b. Place of Disposition (Name of cemetery.	Date 20c. Location - City or Town, State ember 25, 2007 Beltsville, Maryland
Baltir pormit. Departm Importa	21. Signature of Funeral Service Licensee	4339 Hunt Place, N.E. V	ollins Funeral Home, Inc. Washington, D.C. 20019
Physician /Medical `xaminer	23a p.M. Enter the disease, or complications that caused the declarations. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence)		or respiratory arrest, shock, or heart Approximate Interval Between Onset and Death
iner	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence cause. First Underlying Cause		
cuted and transit al Examiner	(Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence d	e of):	
760, cate be executed physician and the burial - transit	UNPENDED AMENDED  IF FEMALE: 23c. If yes, outcome of principles of principles are also as a second of principles are also	regnancy	23d. Date of delivery
p.O. Box 687( that the death certifica ned by the attending ph detached for use as the by Physician/A	23b. Was decedent pregnant in the past 12 months?  1 Ves 2 No 9 Unknown g Unknown	2 Fetal death 3 Ectopic pregr	nancy Month Day Year
res that the casing signed by the be detached	Part II. Other significant conditions contributing to death but no	ot resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?  1 ☐ Yes 2 ✔ No 3 ☐ Probably 4 ☐ Unknown
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transitedical Certification: To Be Completed by Physician/Medical Ex			24a. Was an autopsy performed?  1 ✓ Yes 2 No 124b. Were autopsy findings available prior to completion of cause of death?  1 ✓ Yes 2 No 2 No
Vital Recysician: The his certificate director, page	25. Was case referred to medical examiner? Hospital: 1 Inpatient 2	26.Place of Death (Checi ER/Outpatient 3 DOA Other Nurs	conly one) ing Home 5 Residence 6 ✔ Other: Scene
ion of Vi tending Phys eath. for: After this the funeral di	27. Manner of Death  1 Natural 5 Pending  28a. Date of Injury (Month, Day, Year)	28b. Time of Injury 28c. Injury at Work?  1 Yes 2 No	28d. Describe how injury occurred
Division o spiral or Attending rours after death. Interder: After filled in by the func Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify)	At home, farm, street, factory, office building, etc.	28f. Location (Street and Number or Rural Route Number, City or Town, State)
To the Hospita within 24 hours To the Funeral completely fille	one) 2 Medical Examiner: On the basis of examination and manner stated.		at the time, date and place, and due to the cause(s)
Ž	Patrice Gronics - Poli	Qolcan O.C.M.E.	29d. Date signed (Month, Day, Year) September 17, 2007
CA	Name and address of person who completed cause of death (I Patricia Aronica-Pollak MD. Assistant Medical Assistant		ore, MD 21201
State Registra	NOO7 / /	Special Control of the Control of th	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician James Franklin Hogan September 24, 2007 6:05 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Rockville 12607 Veirs Mill Road Montgomery 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours 1**₩** M 2□ F Yrs Director 212-14-5785 October 1, 1920 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show 1 ☐Yes 2X No notified Director Maryland Montgomery Rockville 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number a or 12607 Veirs Mill Road 23a 20853 LISA Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, or Items 11. Marital Status Black. White, etc. 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2√No Specify: ģ Specify: White 3 ☐ Widowed 4 ☑ Divorced WWITT natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) the 12 Cowboy/Owner & Operator Horsing/Cattle Driving 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William Joseph Hogan Marcella Lucas ို 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) T. K. Benton/Daughter 3731 West Eva Street, Phoenix, Arizona 85051 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State September 29, 1 ☑ Burial 2 ☐ Cremation 3 ☐Removal from State St. Mary's Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 2007 Rockville, Maryland 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd, West, Silver Spring, MD 20901 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or comshock, or heart failure. List only ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Fnd-Stage Parkinson's Disease /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner law requires that the death certificate be executed burial-tra Due to (or as a consequence of): nding physician ause as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Year 4☐Pregnant at time of death 5 Other (specify) 1 Yes 2 No 9 ☐ Unknown signed by the beginning of the detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed' 1☐ Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 反 Residence 6 ☐ Other (Specify) 1 Yes 2√2 No 1 Inpatient 2 ER/Outpatient 3 DOA P 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 ☐ Pending investigation 1 🗹 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Box 68760. <u>о</u> Records, Division or Vital To the Hospital or Attending Physician: hours after death.

uneral Director: / within 24 hours To the Funeral

Baltimore, Maryland 21215-0036

State Registrar

Medical

31. Date filed (Month Pay, 2°5

4 Homicide

(Check only one)

29b. Signature and title of certifier

require

29a. Certifier

Genevieve Wroblewski, MD 6001 Muncaster Mill Road, Rockville, MD 20855 32. Signature

30 Name and address of person who completed cause of death (Item 23a) (Type, Print)



415

🖾 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D64615

29d. Date signed (Month, Day, Year)

September 24, 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** Arthur Elwood HAUSE SEPTEMBER 28, 2007 3:35A.M /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Washington Reeders Memorial Home Boonsboro If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 X M 2 □ F Yrs. 214-09-1917 92 Director Jan.17,1915 Maryland Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits ms 23a or 28a-f show must be notified at 1X Yes 2 No Directo Maryland Washington Hagerstown 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code or items 23a or 21740 USA 1175 Professional Ct., Room 135 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after d Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Examiner Armed Forces: 1 MYes 2 No If Yes, Give Year or Dates: 1945-46 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: white Completed by 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) furniture cabinet maker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Anna Nora French Daniel Randall Hause ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 11822 Greenhill Dr., Hagerstown, Maryland 21742 Rose Shank - niece 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1K Burial 2 ☐ Cremation 3 ☐ Removal from State 10/1/07 Hagerstown, Maryland Rest Haven Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 92. Name and Address of Facility MINNICH FUNERAL HOME 21. Signature of Euneral Service Licens 415 E. Wilson Blvd., Hagerstown, Md. 21740 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Duy to (or as a consequence of): **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last pheada Dw to or as sonsequence of) Examiner or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transif Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4□Pregnant at time of death 5 ☐ Other (specify). 9□Unknown 9 Unknown 22e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 84a. Was an 2 No 1☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Certification: To Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 1 Yes 2 No 4. Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred eral Director: A ler filled in by the furiers 1 Natural 2 Accident Injury 5 ☐ Pending 1 ☐ Yes 2 ☐ No investigation death. 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital within 24 hours a To the Funeral L Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) 29c, License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D32518 92807 , MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ROBERT GUEDENET, 21 WYAND DRIVE, KEEDYSVILLE, MARYLAND 21756 301-432-2222

SH-5+1

Division or Vital Records, P.O. Box 68760.

State Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

			For State Registrer	State of Mar			ment of Ficate of		d Mental Hy	giene Reg. No.		32446
	Physici /Medi		1. Decedent's Name (First, Middle, Last)	-1LL					2. Date of De. Month	Day	9 2 CD	3. Time of Death
	Examir		4a. Facility Name (If not institution, give s		? F	41	o. City, Town, o	r Location of D	PRINC	4c.	County of Deal	
	Funeral Director		5. Social Security Number 6. Sex 0.55 2 2 391 9 10	M 250 7. Age	In yrs. last birt		f Under 1 Year lonths Days	Hours 1	Adia di Cia	th y, Year)	9. Birt	hplace (State or Foreign buntry) New York
	yland now		Usual Residence of Decedent  10a, State 10b, County	1	0c. City, Town	or Locati	ion					10d. Inside City Limits
	e Mar Ba-f sh	Director	Maryland Howard				Colum	bia				1 ☐ Yes 2 ☑ No
	with th	Dire	10e. Street and Number				10f. Zip Code			10g. Citi	zen of What Co	•
	eath ns 23	Funeral	10292 Chestn	ut Park Lane  2. Was Decedent Ev	er in U.S	13 Was	Decedent of H	21044	? (Specify Ves or No		U.S.A	
215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "neture!; or items 23a or 28a-f show other traumatic svent, The Medical Evarinating must be notified at	þ	1 Never Married 2 Married 3 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	or 111 <b>0</b> 10.		es, specify Cuba Yes 2⊠ No	Specify:	? (Specify Yes or No Puerto Rican, etc.)		Black, White	
15-0	"netur	Completed	15. Decedent's Educ (Specify only highest grade		16a.	(Give kind	's Usual Occup d of work done NOT use retired	during most of	working	16b. Ki	ind of Business/	Industry
212	d within	ошо	Elementary/Secondary (0-12)	College (1-4or 5+)		ille. DO	Catere	•			Self er	nployed
pu	be filed ital Hygie d other svent, t	Bec	17. Father's Name (First, Middle, Last)					18. Mother's	Name (First, Middle,	Maiden		
Maryland	d Meni d Meni narke natic	우	William Clark	- 0:0					Frances B	-		
Mai	od 2 sho tth and 27 Is mu trauma		19a. Informant's Name/Relationship (Type Brandon T. Hill - So	*		_			r Rural Route Numbe , Columbia,			. ,
re,	ss 1 and 2 of Health item 27 is other tra	Lia	20a. Method of Disposition		20b. Place of	Dispositio			Date		cation - City or	
imo	Page nent o ant: If ury or		1 △ Burial 2 ☐ Cremation 3 ☐ Ri '4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	Memori			· 1	/26/2007	Eng	lewood, N	New Jersey
Baltimore,	permit. Pages 1 Department of F Important: If ite any injury or ot once.		21 Signature of Funeral Service License	elentos	~	Hin	ame and Addresses Rinals	di Funera	al Home, Inc Avenue, Sir	ver s	pring, Ma	aryland 20904
	Physician /Medical		23. Part1. Enter ne disease, or complie shock, or he it failure. List only on Immedia e e (Final disease or condition resulting in death)	eations that caused the cause on each line.  Due to or as a c	imer	5	Disea		rdiac or respiratory ar	rest,		Approximate Interval Between Onset and Death
	Examiner	iner	Sequentially list conditions, if any, Jacong to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a c								
,8760,	ficate be executed physician and s the burial-transit	dical Examiner	that initiated events resulting in death) Last	Due to (or as a c	consequence o	of):						
P.O. Box 6	The law requires that the death certific site has been signed by the attending p page 2 should be detached for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	ic. If yes, outcome of 1 Live birth 2 ( 4 Pregnant at tin 9 Unknown	Fetal death		opic pregnancy her (specify)			2	23d. Date of deli Month	ivery Day Year
ds, F	uires tha signed I id be det	by	Part II. Other significant conditions con  [muliw dep wa					en in Part I.		obacco u res 2 (		the cause of death?
Records,	aw requir s been s s should	Completed	Severe dem						24a. Was		24b. Were au	topsy findings available
		Com	Failure t		ve				— autop perfor 1 ☐ Yes	rmed? 2 X No	prior to death?	completion of cause of 2 No
Vital	Physicien: The i this certificate ha ral director, page	Be	25. Was case referred to medical examiner?				24	23/242	Death (Check only o	ne)		
o	Phys this ral di	tlon; To	1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	ospital: 1 ☐ Inpatient 28a. Date of Injury (Month, Day Y	2 ER/Out (ear) 28b. T	ime of	DOA Other	at Nursin	ng Home 5 - Resid			cify)
Division	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the funer	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc. (	- At home, far Specify)	m, street.			28f. Location (S City or Tow	Street and m, State)	d Number or Ru )	ral Route Number,
	le Hospit 24 hour le Funer letely fill	Medical	29a. Certifier (Check only one) Certifying Phys	cian: To the best of rest. On the basis of example and manner states	camination and	death oc	curred at the timi gation, in my or	ne, date and pl pinion, death o	lace, and due to the occurred at the time, o	cause(s) date and	and manner as place, and due	stated. to the cause(s)
)	Vithir Comp	M	29b. Signature and title of certifier  Chrw dhy	,m1)			29c. License	3121	-	29d. Date	e signed (Month	n, Day, Year)
	(0		30. Name and address of person who cor NURUL CHUWD F 31. Date filed (Month, Day, Year) SEP 2 4 200		th (Item 23a) (7	Type, Prin			BURTO	NSI	11LLE	, MJ 20866
F	Sta	_	31. Date filed (Month, Day, Year) SEP 2 4 200	32 legistrar's	Signature	hoe	K.					

			For	State of Ma	arylan		artment of H		id Mei	ntal Hygi	iene			
_			State Registrar			Cer	tificate of	Death			g. No. 20	07	32	447
ľ	Physici		Decedent's Name (First, Middle, L Gerald	ast)		Harwoo	od			Date of Death Month	Day	Year	3. Time o	М
	/Medio		4a. Facility Name (If not institution, ga	ive street and number)			4b. City, Town, o	r Location of D		pt. 21	4c. County of	of Death	5:30	JA .
	Maria de proceso, como constituir		419 Russell Ave.				Gaither				Montgo			
	Funeral Director			Sex 7. Ag 1 🖫 M 2 🗆 F 8		last birthday) Yrs.	If Under 1 Year Months Days		Min.	Date of Birth (Month, Day,	Year)	9. Birthplac	y)	
4	Egit, tiles og er		Usual Residence of Decedent		·				No	v. 18,	1919	_New_	York	
	arylan show d at	-	10a. State 10b. County			y, Town or Lo						100		City Limits
	the Ma 28a-f	Director	MD Montgo  10e. Street and Number	mery	Gait	hersbu	10f. Zip Code			140	)= Oitif 146			s 2 No
	3a or			#200			20877			10	)g. Citizen of W			
	death	Funeral	419 Russell Ave	12. Was Decedent Armed Forces?	Ever in U.	S. 13. V	Vas Decedent of H f Yes, specify Cuba	ispanic Origin	? (Specify	Yes or No-	14. Race	d Sta	Indian,	
36	filed within 72 hours after death with the Maryland Hygiene. wher than "natural", or items 23a or 28a-f show ent, the Medical Examinar must be notified at	by Fu	1 Never Married 2 Married	1 ☐ Yes 2 ☐ I If Yes, Give Year or Dates:	No 1942		Tes, specily Cuba	Specify:	ruerto Atc	an, etc.)	Specify:	, White, etc Whi		
Ö	tural'		3 Widowed 4 Divorced	Education	1944		lent's Usual Occup	ation		1	6b. Kind of Bus			
215	thin 72 e. an "na Media	Completed	(Specify only highest gamestary/Secondary (0-12)	rade completed) 5+ College (1-4or 5	5+)	(Give	kind of work done of NOT use retired	during most of	working	I			ou,	
2	filed wil Hygien other the	Con					Attorney				Law			
Maryland 21215-0036	0 = 0 %	To Be	17. Father's Name (First, Middle, Las Samuel Harowitz	,				18. Mother's Cora	,	, , , , ,	laiden Surname	)		
Mar	12 sho h and 7 Is ma		19a. Informant's Name/Relationship			1	g Address (Street				_	_		20874
6	1 and Healt tem 2	1.0	James Q. Harwoo	od/Son	20b. P	lace of Dispos	Millhave		Date		Germanto			
altimore,	Pages ment of tant: If It jury or o		1 ☐ Burial 2 ⚠ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Spec			ional	natorý or other plac Crematory	7 09-	22-2	007 F	alls Ch	urch,	VA	
Ba	permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked any injury or other traumatic evonce.		21. Signature of Funeral Service Lice	ansee			Name and Address		_					,
2			23a. Part1. Enter the disease, or cor shock, or heart fallure. List only	nplications that caused y one cause on each lir	the death	n. Do not ente	er the mode of dyin	g, such as car	rdiac or re	spiratory arre	st,	lr lr	Approxima	etween
	Physician /Medical		immediate Cause (Final disease or condition resulting in death)	_a Myelof								18	nset and mor	nths
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8760,	icate be executed physician and s the burial-transit	dical E		Due to (or as	a consequ	aence or).								
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Box .	the death certificate be executed y the attending physician and iched for use as the bunal-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	23c. If yes, outcome 1□Live birth 4□Pregnant at 9□Unknown	2 Fetal	I death 3	Ectopic pregnancy Other (specify)				23d. Date Mon	of delivery th Da	ay	Year
л О	res that the de signed by the a be detached t	Phy	9 ☐ Unknown  Part II. Other significant conditions		ut not recu	ulting in the un	derlying cause give	on in Port I		23a Did tob	acco use contrib	auto to the	agues of	dooth?
Hecords,	w requires to been signer should be considered.	ed by				nung in the un			_	1 ☐ Yes				
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Vital		Be C	25. Was case referred to medical examiner?					26. Place of	Death (C	1□ Yes 2 heck only one		⊒Yes 2{	□ No	
0	Physiclan: this certific ral director,	2	1 ☐ Yes 2 XNo	Hospital: 1 ☐ Inpatie		ER/Outpatient		4 LI NUISIN			nce 6 Other			
	ing Affer une	tion:	27. Manner of Death  1	28a. Date of Injur (Month, Day	Year)	28b. Time of Injury	28c. Injury Work M 1 □ `	/at <br Yes 2 □ No	28d.	Describe hov	v injury occurre	t		
UIVISION	or Attending after death. I Director: Afte d in by the fune	Certification:	3 Suicide 6 Could not be determined	De 290 Place of inju	ıry - At ho c. <i>(Specify</i>	me, farm, stre			28f.	Location (Stre	eet and Number	r or Rural F	Route Nui	mber,
5	oltal or A urs after eral Dire	Cer	- <del>-</del>						1/1					
	To the Hospital or At within 24 hours after d To the Funeral Direct completely filled in by	ledical	(Check only 2 ☐ Medical Exa	hysician: To the best of miner: On the basis of and manner sta	examinat	wiedge, death tion and/or inv	estigation, in my o	pinion, death o	lace, and occurred a	due to the car at the time, da	use(s) and man te and place, ar	ner as state id due to th	ed. ne cause(	(s)
		Σ	29b. Signature and title of certifier	n. Hagge	sty	m	29c. License	number 2407			d. Date signed  eptembe			7
	10		30. Name and address of person who Joseph M. Haggert	completed cause of de	eath (Item	, , , , ,		Rockvi	illa.		0850	,		
	Sta Registr	te ar	31. Date filed (Month, Day, Year) SEP 2 4 20	2000	1. 0:			1130101	,					
						100	Myddon.							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend #5 per State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) September 23,2007 Physician Gue1da Imirie 12:02A. M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 7351 Willow Road Cottage #9 Frederick Frederick If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 😿 F 73 Director July 24,1934 New Jersey Usual Residence of Decedent r 28a-f show notified at 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No Director Maryland Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or 7 21702 7351 Willow Road Cottage #9 USA Funeral of Health and Mental Hygiene.
item 27 Is marked other than "natural", or items
other traumatic event, the Medical Examiner mi 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0036 1 □ Yes 2 No White Specify Completed by 3K Widowed 4 □ Divorced Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ၉ **Hamilton** Campbell Helen Conroy 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mark E. Imirie/Son 16142 Toms Creek Church Road, Emmitsburg, MD 21727 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Date 20c. Location - City or Town, State Department of Important: If it any Injury or o 4 Donation 5 Dother (Specify) 9/25/2007 | Frederick, MD 21702 Stauffer Crematory 21. Sign ture of Funeral Service 22. Name and Address of Facility Stauffer Funeral Home, PA 1621 Opossumtown Pike, Frederick, MD 21702 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ADENOCIPIE INOMA OF THE GALL BLADNER Physician 9 MONTHS disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physiclan/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 TYes **¾** No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No မှ After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending To the Hospital or Attendir within 24 hours after death.
To the Funeral Director: Ar completely filled in by the fu investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 11x Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29c. License number 29b. Signature and the of certifier 29d. Date signed (Month, Day, Year) 031761 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

BMAN M. O'CONNOR

31. Date filed (Month,

32. Reststrar's Signature

2007

501 W. JEVENTH ST, FREDERICK MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 32449 State
Registrar Ameno#10c.PenFHPGC9-26-07cm Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Dav Year Oluremi Johnson 19 Sept. 2007 9:34 P /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Holy Cross Hospital Silver Spring Montgomery If Under 1 Year If Under 24 Hrs.
Months Days Hours Min Social Security Number Unk. 6. Sex (In ) 59 8. Date of Birth (Month, Day, Year)
Aug. 22,1948 Birthplace (State or Foreign Country) Funeral 1 ☐ M 2 🛣 Days Director Nigeria Usual Residence of Decedent 10a. State 10c. City, Town or Location ral", or items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits Director MD 4008 Eastview Court Yes 2 No Prince George's 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4008 Eastview Court 20716 Funeral Nigeria within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 ☐ Never Married 2 Married 1 ☐ Yes 2 XNo Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify. þ Specify: Black 3 Widowed 4 Divorced "natural", Year or Dates: Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 5+ Pharmacist Pharmacy other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be fill ant of Health and Mental H Be Gladstone Naibi Comfort Williams 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Abiola Johnson-Adelaja/daughter 4008 Eastview Court Bowie, MD. Place of Disposition (Name of cemetery, crematory or other place) Pages 1 20a. Method of Disposition permit. Pages 1 Department of H Important: If itel any Injury or ott Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) Ikoyi Cemetery 10/18/2007 | Lagos, Nigeria 21. Signature of Funeral Service Licens 22. Name and Address of Facility Beall Funeral Home 6512 NW Crain Hwy. Bowie, MD. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Metastatic Breast Cancer yr. /Medical Due to (or as a consequence of): Examiner Malignant pleural effusion Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last month Due to (or as a consequence of). Examiner The law requires that the death certificate be executed Due to (or as a consequence of): burial Division or Vital Records, P.O. Box 68760. Physician/Medical the as IF FEMALE: for use 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed been Was ar. autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 | Yes 2 No 1 Inpatient ဥ 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of Injury 28c. Injury at Work? 28b. Time of Certification: 28d. Describe how injury occurred or Attending (Month, Day Year) 5 Pending thours after death. investigation 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by . Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital of within 24 hours at To the Funeral D 29a. Certifier 1 Ecertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ca (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

and manner stated. analure and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

CLS)

31. Date filed (Month, Day, Year) SFP 2 6 2007

AHUVED

NAWAZMO POBOX 83819 Gachersburg mo 20883

Day Year) Lever S. Species;

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

Registrar

D50987

			1 - For State Registrar	State of	Marylan		artment of I rtificate of		d Mental Hy		2007	32450
	. <u> </u>		Decedent's Name (First, Middle, Language)	ast)			imouto or	Dodan	2. Date of D		2001	3. Time of Death
	Physici /Medic		ISSAC JOHNSON						Month 09/20	)/2007	Year	3:00 P M
	Examin		4a. Facility Name (If not institution, gi		per)		4b. City, Town, o	or Location of De	eath	4c. C	ounty of Death	
		4	FUTURE CARE NURS		A (1	to a table to the	BALTIMO If Under 1 Year		dro To D			
ď	Funeral Director		5. Social Security Number 6. 251-46-8461	Sex 7. 1XIM 2□ F	. Age (In yrs. 75	iast birthday) Yrs.	Months Days		Hrs. 8. Date of Bi (Month, D 01/07/	rth ay, Year) /1032	9. Birthp Cour	place (State or Foreign ptry) PVILLE, SC
i diga	2-5400		Usual Residence of Decedent		- 75				01/0//	1952	prono	IVILLE, BC
	arylan show d at	_	10a. State 10b. County		10c. Cit	y, Town or Lo	cation				1	10d. Inside City Limits
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	with t	ă	10e. Street and Number 6207 BRIGHTLEA DI	OTWE			10f. Zip Code 20706			USA	n of What Cour	itry?
	ms 23	Funeral	11. Marital Status	12. Was Decede			Nas Decedent of H	lispanic Origin?	(Specify Yes or N		. Race - Americ	an Indian,
21215-0036	be filed within 72 hours after death with the Maryland ital Hygiene. so other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at	Ď	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forc 1 ☐ Yes 2 If Yes, Give Year or Date	. No		f Yes, specify Cub 1 ☐ Yes 2X No	an, Mexican, Pu Specify:	uèrto Rican, etc.)		Black, White, pecify: BLA	
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Maryland	2 should be filed within and Mental Hygiene. Is marked other than aumatic event, the M		19a. Informant's Name/Relationship	(Type. Print)		19b. Mailin	g Address (Street	and Number or	Rural Route Numi	per, City or T	own, State, Zip	Code)
	and sealth m 27		JANIE GALMON/SIST	<u>rer</u>	1657				LANHAM,			
altimore,	Pages 1 nent of H int: If ite iry or ot		20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3 ☐				sition (Name of natory or other pla		Date / 2007		tion - City or To	,
Ħ	iit. Pa artmer ortant: injury		4 ☐ Donation 5 ☐ Other (Special Signature of Funeral Service Lice	**	HAR		EMORIAL :		.B. JERKI	1	OVER, M	
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O. Box	law requires that the death certific as been signed by the attending p 2 should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		h 2□Feta nt at time of d	Ideath 3	Ectopic pregnancy Other (specify)	y		230	d. Date of delive Month	ery Day Year
7	uires that the de signed by the a Id be detached f		Part II. Other significant conditions	contributing to deal	th but not resu	ulting in the ur	nderlying cause giv	en in Part I.	23e. Did	tobacco use	contribute to th	ne cause of death?
ecords,	w requires been sign should be	ed by	seizure dis	arder					_ 1 🗆	Yes 2□I	No 3 ☐ Prob	ably 4 Donknown
000	law re as bee	ompleted	Advance d	emente	a				24a. Was		24b. Were auto	psy findings available
Υ	The ate he page	Com							- auto perf 1 Yes	ormed?	death?	mpletion of cause of 2 □ No
VItal	sician: The law certificate has b irector, page 2 s	Be (	25. Was case referred to medical examiner?	Hospital:			104		Death (Check only			
0	this ald	2	1 Yes 2 No  27. Manner of Death	28a. Date of		ER/Outpatien	t 3 DOA Oth	4 M Nursing	g Home 5 ☐ Res			()
0	Attending Ph r death. ector: After th by the funeral	ţ	1 Natural 5 Pending 2 Accident investigatio	(Month,	Day Year)	Injury	Wor	yai k? Yes 2∐No	28d. Describe	now injury o	ccurred	
UNISION	al or Attendi safter death. I Director: A d in by the fu	ifica	3 Suicide 6 Could not be determined	28e. Place of	injury - At ho	me, farm, stre	eet, factory, office	7.1	28f. Location (	Street and N	Number or Rura	I Route Number,
5	tal or rs afte al Dir	Certification:	4 - Homotec	Dunding	, etc. (Specif)				City or To	wn, State)		
	Hosp 4 hou Funel tely fil	Medical (	29a. Certifier 1 Certifying Pl (Check only one) 2 Medical Exa	hysician: To the be miner: On the basi and manner	is of examinat	wledge, death tion and/or inv	occurred at the til estigation, in my o	me, date and pla opinion, death o	ace, and due to the ccurred at the time	cause(s) an , date and pl	nd manner as st ace, and due to	ated. the cause(s)
	To the within 2 To the complex	Σ	29b. Signature and title of certifier				29c. Licens		7		signed (Month,	Day, Year)
	70		11 hair					3912		9/2	23/20	00/
1	(4)		30. Name and address of person who				,	ODE 35	21201			
	Sta	te	31. Date filed (Month, Day, Year)	ORTH EUTA 32. Reg	istrar's Signa	<u>ET #10</u>	3 RALTIM	UKE, MD	21201			
	Registra	ar	SEP 2 6 2007	Seem 32. Reg	D. 19	our						

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene, 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** Ora Elizabeth Jackson September 21, 2007 10:43A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington Adventist Hospital Takoma Park Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs. Funeral 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Months Hours 1 ☐ M 2 € F Yrs. Director 577-44-7892 DC Usual Residence of Decedent the Maryland 10a. State 10h County 10c. City, Town or Location ?7 is marked other then "natural", or Itama 23a or 28a-f ehow traumatic event, the Mudical Examinar must be notified at 10d. Inside City Limits Director DC 1 Yes 2 □ No Washington 10e. Street and Number 10f. Zip Code permit. Pages 1 and 2 should be filed within 72 hours after death with t. Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural" — any injury or other traumatic event. 10g, Citizen of What Country? 1502 Decatur Street, NW 20011 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: by Specify: Black 3 ☐ Widowed 4 ☑ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 2 yrs. Technical Information Spec. Defense Mapping Agency 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ဂ္ William Morris Gray Eleanor Braxton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Maureen L. Bostic/Daughter 107 Rambling Road, Lumberton, NJ 08048 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Memorial Pk. 10-01-2007 Landover, MD
22. Name and Address of Facility Marshall's Funeral Home, Inc. Harmony Memorial Pk. 21. Signature of Funeral Service Licenses 4217 9th Street, NW Washington, DC 20011 Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death CA RIAC SUDOEN tmmediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of):

CITE MYOCA ROIAC Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit ARTORY DISFASE ORDNA RY resulting in death) Last Due to (or as a consequence of): Box 68760. Be Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 XNo 4☐Pregnant at time of death Month Day Year P.O. 5 Other (specify) 9 Unknown 9 Unknown Partyll. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ENCEDNAMODATHI 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown RENAL FAILURE 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? ENCE PMALOPATHY 25. Was case referred to medical 1 ☐ Yes 2 No 26. Place of Death Check only one examiner' Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 🖾 No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 ☑ Natural 5 Pending after death. investigation 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check on one) 29b. Signatur And title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. PIOTR M. WYRWINSKI 7600 Carroll Avenue, Takoma Park, MD 20912 31. Date filed (Month, Day, Year) SEP 2 6 2007 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

			<b>1 =</b> For State Registrar	State of I	Maryland	d / Depa	artment of rtificate o	Health f Death	and M	ental Hy	giene Reg. No. 20	07	32	452
	Physici /Medi		1. Decedent's Name (First, Middle,  Mary B.	Johnson						2. Date of De Month Septemb	Day er 14, 2	Year 2007	3. Time of 9:50	Death A M
	Examir Funeral	ner	4a. Facility Name (If not institution,  Washington Adv  5. Social Security Number	entist Hos	·	ast birthday)	4b. City, Towr	ma Pai	rk	8. Date of Birt	4c. County of	gomer	y ace (State o	r Foreian
L	Director		578-30-3764 Usual Residence of Decedent	1□M 2 <b>½</b> F	88	Yrs.	Months Day	rs Hours	1	(Month, Da	y, Year) 1919	Nor	th Car	colina
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	To Be Completed by Funeral Director	10a. State   10b. County   Maryland   Montg.   10e. Street and Number   600 Ray Drive   11. Marital Status   1 Never Married 2 Married 3 Widowed 4 Divorced   15. Decedent's (Specify only highest Elementary/Secondary (0-12)   12 Years   17. Father's Name (First, Middle, L. Unknown   19a. Informant's Name/Relationshi   Bobby R. Hill - 20a. Method of Disposition   1 Burial 2 Cremation   4 Donation 5 Other (Specify only property of the country of the cou	12. Was Decede Armed Force 1	Si  nt Ever in U.s. s: No s: or 5+)	16a. Dece (Give life.  19b. Mailli 600 I ace of Disponentery, cre	Spring  10f. Zip Cod  2091  Was Decedent of Yes, specify Codent's Usual Occupation of Work do NOT use retained the Company of	of Hispanic Ouban, Mexica lo Specify supation reduring mored)  18. Moth  18. Moth  Pet and Number Silver Cemt.	ner's Name Maggie ber or Rura Ter Sp  D  Sept	cify Yes or No Rican, etc.)  ng  (First, Middle, Hill Houte Number Oring, ate 22, 2	Specify:  16b. Kind of Bus Priva  Maiden Surname  ar, City or Town, S MD 20910  20c. Location - C 007 Scot	State America White, e Blassiness/Indu	es In Indian, tc. ack ustry  Code)  vn, State  Neck,	2 No
I	Physician //Medical Examiner	dical Examiner	23a. Part (Enter the disease, or on shock, or heart failure. List of immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Love to (or b. Love to (or c.	utI	Do not end end end end end end end end end end	2. Name and Ad 4001 Bern ter the mode of o	ning F	lity Stev Road, s cardiac o	vart Fu NE Was	neral Ho hington,	DC 2	Inc.	e ween
ecords, P.O. Box 6	The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	Be Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown  Part II. Other significant condition  25. Was case referred to medical examiner?	4□Pregnant 9□Unknown  is contributing to death	2 ☐ Fetal t at time of de	death 3 Lath 5 L		given in Part  26. Place	e of Death	24a. Was autop perfo	obacco use contri ves 22 No an 24b. W py rmed? 2 No 1	bute to the	Day You cause of dubly 4 \( \subseteq \text{U} \)  Sy findings appletion of cause of the cause o	Jnknown available
DIVISION OF	Atten r death ector: by the	Certification: To	27. Manner of Death  1 Natural 2 Accident 3 Suicide 4 Homicide  202 Certifier  203 Certifier 203 Certifier	28a. Date of little (Month, I be ed 28e. Place of building,	njury Day Year) injury - At hor etc. (Specify,	)	f 28c. Ir W 1 eet, factory, office	ury at ork? Yes 2☐	]No 2	28d. Describe h		ed er or Rural	Route Num	ber,
	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in I	Medical	29a. Certifier (Check only one)  29b. Signature and title of certifier	Physician: To the be kaminer: On the basis and manner	of examinati	viedge, deat ion and/or in	vestigation, in m	time, date a y opinion, de nse number	and place, a	ed at the time,	cause(s) and mar date and place, a 29d. Date signed	ind due to	the cause(s	)
2	(6)		30. Name and address of person w				Print) Ave. T	7614 okoma	Park	MD 20	Septemb	er 22	2, 200	7
į	Sta Registr		31. Date filed (Month, Day, Year) SEP 2 5 2007	- /////	strar's Signat		. 11420 I	OROMA.	TOTES	1.11 2.0				

State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No 2007 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** FRANCES JONES SEPTEMBER 14, 2007 10:15 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner St. Mary's County 46112 Lucca Way Lexington Park, MD If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 10-27-1952 9. Birthplace (State or Foreign 6. Sex 7. Age (In vrs. last birthday **Funeral** Months Days Hours Min. 1 □ M 2 XF Maryland Director 214-58-2334 54 Usual Residence of Decedent 10c. City. Town or Location 10b. County 10a State 10d. Inside City Limits 28a-f show Examiner must be notifled at 1 ZYes 2 No Director MD Lexington Park ST. MARY'S 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with ō 46112 Lucca Way 20653 USA items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ★ Yes 2 □ No If Yes, Give VIETNAM— Year or Dates: F.KA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. Pages 1 and 2 should be filed within 72 hours after one of Health and Mental Hygiene.
Int: If item 27 is marked other than "natural", or iter any or other traumattc event, the Medical Examiner. 1 Never Married 2 Married **Black** 1 ☐ Yes Ž No Baltimore, Maryland 21215-0036 Š Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Secretary years Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Fletcher Sarah Louise Stewart ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 46112 Lucca Way, Lexington Park, MD 20653 19a. Informant's Name/Relationship (Type. Print) Rahsaan Jones - Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If ite
any injury or ot 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Resurrection Cemetery 9/21/2007 Clinton, MD 4 ☐ Donation 5 ☑ Other (Specify) 01 Signature of Puneral Service I 22. Name and Address of Facility J.B. Jenkins Funeral Home ense 7474 Landover Road, Landover, MD 20785 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final COLON CANCER **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): physician at the burial-t Division or Vital Records, P.O. Box 68760. Physician/Medical as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 5 Other (specify) the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ☒ No 24a, Was an autopsy page performed? es 2 No certificate director. 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 🔀 Residence 6 Nother (Specify) 1 ☐ Yes 2 No P 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation After (Month, Day Year) Injury 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident Director; / 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after or To the Funeral Direct completely filled in by 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD# 33255 SEPTEMBER 21, 2007 Blackstone no 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KAREN ANN BLACKSTONE, M.D., VAMC, 50 IRVING STREET NW, WASHINGTON, DC 20422/688 32. Registrar's Signature 31. Date filed (Month, Day, Year, State 5 2007 Registrar 2

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Sept. 20, Day 2007 Year Physician 22:25 Willie Christine Johnson /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** Montgomery Washington Adventist Hospital Takoma Park If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birtholace (State or Foreign Country) 4. Aug. 30, 1951 Knoxville, Tenn 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Months Days Hours 1 □ M 2 😾 F 408-94-2395 56 Director Usual Residence of Decedent 10d. Inside City Limits 10c, City, Town or Location 10a. State 10b. County 1X Yes 2 □ No Park Takoma Maryland | Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U. S. A. 20912-4827 6713 Gude Avenue filed within 72 hours after death Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ▼No 1 Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates: Specify: Black þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Value Village Store 12th. other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Is marked oth any lighty or other traumatic event size. Isadora Campell Gerna M. Johnson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Andy Bradley (Fiance 6713 Gude Avenue Takoma Park Md. 20912-4827 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Sept. 26'07 Washington, D.c. Mt Olivet Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 3831 Georgia Avenue, NW 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Latney's Funeral Home Washington, D. C. 20011 MD 278 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death · PERSISTENT COAGULOPATHY WITH OROPHARYAGEAL BLEED Immediate Cause (Final Physician disease or condition resulting in death) /Medical HEPATIC CELL FAILURE MITH HEPATIC COMA, AND SAUNDIGE Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner c. ALCOHOLIC LIVER DISEASE WITH CIRRHOSIS 3

Due to (or as a consequence of): HEPATITIS -C burial-transit resulting in death) Last Completed by Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy 1☐Live birth 2☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy Month Year Day 4 Pregnant at time of death 5 ☐ Other (specify) signed by the et d be detached fo Ö 9 Unknown مَ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

SEPSIS - GRAMNEGATIVE > 2 TENAL FAILURE) 23e. Did tobacco use contribute to the cause of death? Records, 1 Yes 2 No 3 Probably 4 Unknown RESPIRATORY FAILDIRE, WHITEMEDICATIONENIA 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2□ No TO REMOPERATIONIAL HEMATOMA 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 V npatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ٩ ō 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification: Division 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number SEPTEMBER 21,2007. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31-TOLEDOTENLACE MOHAMMED A. MANNAM M.D.) 31. Date filed (Month, Day, Year) SEP 25 State 2007 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** Month 20, 2007 RICHALYN Κ. JOHNSON SEPT. 2:25 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Washington Adventist Hospital Takoma Park MONTGOMERY If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days 1 □ M 2√2 F Months 62 Director 227-58-0683 Nov.8,1944 Virginia Usual Residence of Decedent 10a. State 10c. City, Town or Location 10h. County 10d. Inside City Limits show r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at Director 1 ☐ Yes 2 No MDMontgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1205 Smith Village Road 20904 Funeral U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. within 72 hours after 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify þ Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) yrs Housewife Home s 1 and 2 should be filed w f Health and Mental Hygier Item 27 is marked other th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Richard O. Key Fannie Willis 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Haywood Johnson (Husband) 1205 Smith Village Rd, Silver Spring, MD permit. Pages 1 an Department of Heal Important: If Item 2 any Injury or other Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place Mt, Calvary Church Cem 20a. Method of Disposition 20c. Location - City or Town, State Bapt 9/27/07 1 Surial 2 □ Cremation 3 Removal from State 4 Dopation 5 Other (Specify)
Signature of Funeral Service Lice is Powhatan, VA 22. Name and Address of Facility SNOWDEN FUNERAL HOME, P.A. -246 N. Washington St, Rockville, MD 20850 23a. Part1. Enter the disease, or complications that caused the death Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heaft failure. List only one cause on each line. Immediate Cause (F disease or condition resulting in death) (Final **Physician** /Medical Examiner Gagueritally fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner that the death certificate be executed and burial-trar Due to (or as a consequence of): Box 68760 physician Physician/Medical the attending IF FEMALE: nse If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f P.O. 9 Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 1 Tyes 2 No 3 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has page 2 autopsy perform certificate Division or Vital 2 No 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA P this Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Certification: Hospital or Attending 1 Natural 5 Pending investigation Injury ithin 24 hours after death.

the Funeral Director: A

mpletely filled in by the fu 1 ☐ Yes 2 ☐ No hours after death. 2 Accident 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 🖵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day,

2 5

5

and address of person who completed cause of death (Item 23a) (Type, Print)

egistrar's Signatu

2 2 29c. License number

29d. Date signed (Month, Day, Year)

# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2007

32456

				Ce	ertificate of Death		Reg. No.	
	Physic		1. Decedent's Name (First, Middle, Last)	Joves		2. Date of De Month	Day Ye	3. Time of Death
1	/Medi Examii		4a. Facijity Name (If not institution, give street and n	umber)	, 4b. City, To	own, or Location of Deat	h 4c. County of I	
	Funeral Director		5. Social Security Number 216-60-9471  Usual Residence of Decedent	7. Age (In yrs. last birthday 56 Yrs.		24 Hrs. 8. Date of Bir Min. Month, Da April	16 1061	Birthplace (State or Foreign Country) Minnesota
	Maryland a-f show	ctor	10a. State 10b. County MD Anne Arundel	10c. City, Town or L Annapol				10d. Inside City Limits 1X Yes 2 □ No
	th with th	al Dire	10e. Street and Number 186 Woods Drive		10f. Zip Code 21403		10g. Citizen of Wha	at Country? USA
020	iges 1 and 2 should be filed within 72 hours after death with the Maryland not Health and Mental Hygiene. If item 27 is merked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Evar inst must be notified at	Completed by Funeral Director	Armed	2 No Rive 1974 –	Was Decedent of Hispanic Or If Yes, specify Cuban, Mexica 1 ☐ Yes 2 ☑ No Specify		Specify: [	American Indian, White, etc. White
21215-0020	filed within 72 h Hygiene. Ither than "natu	ompletec	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College 2	16a. Dece (Give //:4or 5+)	edent's Usual Occupation e kind of work done during mos DO NOT use retired) Etrician	st of working	16b. Kind of Busin	ness/Industry
Maryland	should be filed and Mental Hygid marked other umatic event, the	To Be C	17. Father's Name (First, Middle, Last) Wesley Norwood Jones	1		er's Name <i>(First, Middle</i> ginía Louíse		
	1 and 2 sho Health and I Hem 27 is ma Sther traume		19a. Informant's Name/Relationship (Type, Print) Virginia Louise Jones/M	other 713	ing Address (Street and Numb Pin Oak Road,	Severna Pa	rk, Maryla	and 21146
altimore,	~ = = >		20a. Method of Disposition  1 Burial 2 Cremation 3 Removal from 4 Donation 5 Other (Specify)	20b. Place of Disp cemetery, cre Metro Cr	ematory or other place)	Sept. 24,2007	20c. Location - Cit Baltimor	
Balt	pemit. Pa Departmer Important: any injury once.		21. Sinature / Funeral Savick Licensie	Some 4	2. Name and Address of Facili Barranco & Sons 95 Gov. Ritch	s, P.A. Seve ie Hwy, Seve	erna Park	, MD 21146
	Physician /Medical	1	Enter the disease, or co blications that s c y heart failure. List only one cause on the comment of the comment	each line.	ter the mode of dying, such as			Approximate Interval Between Onset and Death
	Examiner	Iner	resulting in death) a.	Due to (or as a conse		,-,,,,		
60,	certificate be executed ding physician and ise as the burial-transit	al Examiner	Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury c.	Due to (or as a conse	quence ol <i>j</i> .			
ox 68760,		n/Medical	that initiated events resulting in death) Last	Due to (or as a conse	quence of):			
P.O. B	death e atte	y Physiclan	Part II. Other significant conditions contributing to	death but not resulting in the (	underlying cause given in Part		1922-1 7-7-1	bute to the cause of death?
ecords	aw requir as been s 2 should	Completed by					an autopsy 2 ormed?	24b. Were autopsy findings available prior to completion of cause of death?
of Vital Records,	Physician: The I rithis certificate he rral director, page	Be	25. Was case referred to medical examiner? Hospital:		Other:	1 □ e of Death (Check only	one)	1 ☐ Yes 2 ☐ No
Division of	tending leath. tor: After the fune	Certification: To	27. Manner of Death   Natural   5	Inpatient 2 FER/Outpaties of Injury nth, Day Year)  28b. Time Injury Injury - At home, farm, stilling, etc. (Specify)	of 28c. Injury at Work?  M 1 Yes 2	No	how injury occurred  Street and Number of	or Rural Route Number,
	Hospita 24 hours Funeral tely fille	edicai Cer	29a. Certifier (Check only one) (Check only one)	pasis of examination and/or in				
	To the within 2 To the comple	Mec	29b. Signature and title of certifier	Deput	29c. License number	154	29d. Date signed (A	Month, Day, Year)
L	41(4		William Pus Too	iso of death (Item 23a) (Type VRB, MD	Print) 695 K	merica	4 910	0.55
	Sta Registr	ar	31. Date filed (Month, Day, Year) 32.	gistrar's Signature	book			

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hydiene

sepn K. Johns		State of Maryland 1-For State Registrar		ment of H icate of D		d Mental H		. No. 200	7 3245
Physicia	an/	Decedent's Name (First, Middle,Last)		_			2. Date of Death Month September		3. Time of Death 1636 hrs
ledical Exami ⊸		Joseph K  4a. Facility Name (if not institution, give street and numb	er)		hnson City, Town, or	Location of Death		20, 2007 4c. County of Death	
		Cherry Hill Road at O'Fallon	•	s	ilver Sprin	g		Montgomery	_
Funeral			Age (In yrs. last t		Under 1 Year		_	(MM/DD/YYYY) 9. Bir Foreig	thplace (State or I <sup>n</sup> Maryland
Director		213-06-2405 1XM 2F	39	Yrs.		100	01/09	/1968 <sup>co</sup>	untry) — 1 — 1 — 1
any;	× 1/2	Usual Residence of Decedent  10a. State 10b. County	10c. City, Tov	wn or Location					10d. Inside City Limits
Aaryland 28a-f show any; 1 at once	ō	Maryland Baltimore	Ra	ndells	stown		JAL I		1 X Yes 2 No
th the Maryland 23a or 28a-f sho notified at once	rector	10e. Street and Number			f. Zip Code		:. : 100	g. Citizen of What Cou	ntry?
rith the s 23a o	al Di	3810 Nemo Road  11. Marital Status 12. Was Decede	ent Ever in U.S.		21133	spanic Origin? ( S	pecify Yes or No-	USA 14. Race - Amer	ican Indian, Black,
Jeath w	Funeral	1 Never Married 2 X Married Armed Force				n, Mexican, Puerto		White, etc.	-61
after c	by F	3 Widowed 4 Divorced If Yes, Give Year or Dates:			s 2 X No		,	Specify: Bl	
5-0036 led within 72 hours afte tygiene. other than "natural", the Medical Examiner	ted	15. Decedent's Education (Specify only highest grade of Elementary/Secondary (0-12)  College (1-4)	,			tion (Give kind of e. DO NOT use ret		16b. Kind of Business/	Industry
036 ithin 72 ne. r than ledical	ompleted	12		Assist	ant S	upervis	sor	Astor San	ders
5-00 iled wit Hygien I other the M	ပ	17. Father's Name (First, Middle, Last)				18.Mother's Name	e (First, Middle, M	•	
21215-0036 und be filed within 7 Mental Hygiene. marked other than c event, the Medica		Joseph M  19a. Informant's Name/Relationship (Type, Print )		ters 19b. Mailing Ad		Bertha	Rural Route Numb	Joh per, City or Town, State	INSON e: Zip Code)
imore, MD 2121 Pages I and 2 should be fi ment of Health and Mental fant: If item 27 is marked or other traumatic event,	۱	Sharon Johnson/ Wife		_				n,Marylan	
ore, Nest I and of Health If item		20a. Method of Disposition  1  Purial 2 Cremation 3 Removal from		ce of Disposition natory or other		emetery,	Date	20c. Location - City or	Town, State
Baltimore, permit. Pages I ar Department of Hee Important: If ite injury or other tr		4 Donation 5 Other Specify:	Resu	rrecti					Maryland
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygient Annual of Health and Mental Hygient I manatural. If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once		21. Signature   Funeral Service Licenses	191	22. Nam	e and Addres	s of FacilityAda	ms Fund	eral Home	s PA yland2060
Physician		23a. Part I. Enter the disease, or complications that caus		not enter the n	node of dying	such as cardiac	or respiratory arre	st, shock, or heart	Approximate Interval Between Onset and
/Medical `xaminer	37 E	failure. List only one cause on each line.  Immediate Cause (Final disease a. Multiple Injuri	es				3		Death Death
xaiiiiici		or condition resulting in death)  Due to (or as a co	nsequence of):						
	je.	Sequentially list conditions, if any, leading to immediate Due to (or as a co	nsequence of):			The same			
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a co	nsequence of):						
cecuted 1 and - transit		d							
<b>60,</b> nte be exo hysician e burial -	sician/Medical	UNPENDED						_	
Box 6876( ne death certificate the attending physele for use as the b	W/u	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, out	come of pregnar	2 Fetal o	death 3	Ectopic pregn	ancy	23d. Date of deliver Month	y Day Year
ox 6 ath cer attendi	sicia	4 Pregnan	t at time of death	5 Other	(Specify)			B.	
	F.	Part II. Other significant conditions contributing to de		Iting in the unde	erlying cause	given in Part I.	23e. Did tot	pacco use contribute to	the cause of death?
cords, P.O. law requires that that been signed be 2 should be detailed.	d by						1 Yes	2 No 3 Pro	bably 4 Unknown
ords v requi s been should	ete						24a. Was a autops		utopsy findings available completion of cause of
RecC The lav	Completed						perform 1 ✓ Yes 2		es 2 No
Vital Reco hysician: The law this certificate has I director, page 2 s	Bec	25. Was case referred to medical examiner?   Hospital:				e of Death (Check			
of Vi ing Physi After this funeral di	. To	1 V Yes 2 No	Injury 28	R/Outpatient 3  Bb. Time of Injur		ury at Work?		Residence 6  Othe	er: Scene
ion of tending Pheath.	tion	1 Natural 5 Pending FOUND:	ay,Year) F	OUND: 627 hrs	1	Yes 2 ✔ No	Operator mo	otorcycle collision	1
visi or Att ffer de Directe in by 1	ertification:		of Injury - At home		actory, office	building, etc.	28f. Location (S or Town, St		ural Route Number, City
Divisior  To the Hospital or Attend within 24 hours after death To the Funcral Director: completely filted in by the	O	00-0-46	_ocal Street				Cherry Hill Roa	ad at O'Fallon, Silve	
the Ho hin 24 the Fu	edical	(Check only one) 2 Medical Examiner: On the basis of e	examination and/	death occurred or investigation	at the time, on the street, or the s	date and place, an in, death occurred	d due to the cause at the time, date a	e(s) and manner as sta and place, and due to t	ted. ne cause(s)
To vitil	Mec	29b. Signature and title of certifier	ed.		_	se number		29d. Date signed (Mo	
		Donna mi incenti,	M.D.		O.C	.M.E.		September 21, 2	2007
Car		30. Name and address of person who completed cause			C'	4 Dol4:	4D 24204		
PPD		Donna M. Vincenti, MD Assistant Me  31. Date filed (Month, Day, Year) 32. Regi	dical Examir	ier 111 P	enn Stree	t, Baltimore, N	/ID 2 1201		
S Regis	tate trar	SFP 2 5 2007		4 Spai	El.			···	
DHMH 17 Rev 1/2	2001	OCAAF	(	ORIGINAL					

			1 - For Amend Items	State of Maryland / De 25,27,28a-fper ME	partment of He	ealth and M	lental Hygie	2007	32458
	Physici	ian	Decedent's Name (First, Middle, Last)				2. Date of Death Month Day SepTember 27 2007 3. Time of Death 7:20 A M		
	/Medi Examir	cal	Charles Rufus Jessop  4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death			ocation of Death	<del></del>		
	Exami	iei	Williamsport Ret			amsport		Washing	
	Funeral Director		5. Social Security Number 6. Sec. 205–10–2357		Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Aug. 27, 1		place (State or Foreign Intry) ary land
	Maryland f show	tor	Usual Residence of Decedent  10a. State 10b. County  Maryland Washir	10c. City, Town o	Williamspe	ort			10d. Inside City Limits
	after death with the Maryla or iteme 23s or 28s-f shor nicer must be notified at	Funeral Director	10e. Street and Number		10f. Zip Code		10g	. Citizen of What Cou	-
	eath w	eral	10608 Honeyfiel			795	oitu Vas es No	US/	
980		by Fun	1 Never Married 2 Married 3 Widowed 4 Divorced	Amed Forces?  1 Mayes 2 No 1944- If Yes, Give Year or Dates: 1945	13. Was Decedent of Hisp If Yes, specify Cuban, 1 ☐ Yes 2 No	Mexican, Puerto	Rican, etc.)	Black, White	
15-0036		Completed by	15. Decedent's Edu (Specify only highest grad	cation 16a. De completed) (G	ecedent's Usual Occupati live kind of work done du fe. DO NOT use retired)	ion iring most of worki	ng 16	b. Kind of Business/li	ndustry
2121	d within giene. er than	Comp	Elementary/Secondary (0-12)	College (1-4or 5+)	Executive I			n-Profit (	Organization
	ges 1 and 2 should be filed withi t of Health and Mental Hygiene. If item 27 is marked other than or other traumatic event, the M	Be	17. Father's Name (First, Middle, Last)		1		(First, Middle, Ma	·	
Maryland		2	George Franklin  19a. Informant's Name/Relationship (Ty		lailing Address (Street an	Edna nd Number or Rura	Thoma Il Route Number, C		p Code)
	ges 1 and 2 s of Health an if item 27 is or other trau		Michael E. Taylor		12 Woodvale		_	Maryland	21740
nore	ages 1 int of H t: If ite y or ot		20a. Method of Disposition  1 ☐ Burial 2 【X Cremation 3 ☐ F  4 ☐ Donation 5 ☐ Other (Secirl)	Removal from State cemetery,	isposition (Name of crematory or other place)	) <u>l</u>		c. Location - City or T	
Baltimore	permit. Pag Department Important: I eny Injury o		21. Signature of Funeral Service Vicen	99	rg Cremator Osborne AFun 425 S. Cono	erferling Home	e, P.A.	liamsport	
	Physician /Medical Examiner	3	23a. Pant: Enter the disease, or complishock, or heart failure. List only or	ications that caused the death. Do not				1	Approximate Interval Between
			Immediate Cause (Final disease or condition resulting in death)	RENAL FAIL	URE			In Priss	Onset and Death
			f	Due to (or as a consequence of):  CHRONIC RECUR		EN TRACK	1 INFECT	CAN EXAMINER	
	ed sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to for as a consequence of					
Ċ,	execution and sal-tran	Examiner	that initiated events resulting in death) Last	NEWROGENIC  Due to (or as a consequence of):	BLADDER	CENT	m / /		
68760,	ificate be executed g physician and as the burial-transit	edical		. C7 CERVICAL	CORD I	UJURY,	MARCH.	2001	6 YEARS
P.O Box	The law requires that the death certificate be executed tables been signed by the attending physician and pege 2 should be deteched for use as the burial-transli	by Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregnancy  1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown	3 □Ectopic pregnancy 5 □ Other (specify)			23d. Date of deliv Month	Pery Day Year
			Part II. Other significant conditions con	ntributing to death but not resulting in the underlying cause given in Part I.			23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown		
Il Records,		Completed					24a. Was an autopsy performed	d? prior to co	opsy findings available ompletion of cause of
of Vital	Physician: Th this certificate al director, peg	Be	25. Was case referred to medical examiner?	lospital:	Other		Check only one)		
	ding Phys	n; To	27. Manner of Death	1 Inpatient 2 ER/Outpatient 3 DOA Sure 1 A Nursing Home 5 Residence 6 Other (Specify)  28a. Date of Injury (Month, Day Year)  28b. Time of Injury at Work?  28c. Injury at Work?					
sion		atlo	1 Natural 5 Pending investigation	March 2001 Unkn		es 2 No	Subject	fell.	
Division	i or Att after de Direct	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, building, etc. (Specify)		1	City or Town, S		
_	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	edical C	ZSa. Certifier IX Certifying Physical (Chack only one) 2 Medical Examination	Wooded area near  sician: To the best of my knowledge, of the basis of examination and/of and manner stated.	eath occurred at the time.	, date and place, a nion, death occurre	and due to the caus	ont, Mary1; se(s) and manner as a and place, and due	stated
	To the within To the	Me	29b. Signature and title of certifier		29c. License r			. Date signed (Month)	
		И	30. Name and address of person who co		D33	100	5	eptember	27, 2007
5	H-2+1		TEDE. HOWE 154	EN. ARTIZAN ST.	WILLIAMS	PORTI MI	2179	75	
	Sta Registr		31. Date filed (Month, Day, Year)  SEP 2 8 20	32. Begistrar's Signature	Sparke				

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

	1- For State of Maryland / Department of Health and Mental Hygiene  Certificate of Death  Reg. No. 2007	321.5								
ian cal	1. Decedent's Name (First, Middle, Last)  2. Date of Death  Susan Kahn  Sont 2007  Year	3. Time of Death								
ner										
2	115 10-4501 A 85 DEG. 13, 1921 Ger	place (State or Foreign intry) many								
Be Completed by Funeral Director		10d. Inside City Limits								
	Maryland Montgomery Silver Spring	1 ☐ Yes 2☐ No								
	10e. Street and Number  10f. Zip Code  10g. Citizen of What C  1131 University West Blvd #1605  11. Marital Status  1 Never Married 2 Married  12. Was Decedent Ever in U.S. Armed Forces?  1 Never Married 2 Married  1 Never Married 2 Married  1 Never Married 4 Divorced  1 Never Married 4 Divorced  1 Never Married 5 Never Married 2 Married  1 Never Married 5 Never Married 5 Never Married 5 Never Married 5 Never Married 5 Never Married 5 Never Married 5 Never Married 5 Never Married 5 Never Married 5 Never Married 5 Never Married 5 Never Married 5 Never Married 6 Never Married 6 Never Married 7 Never Married 8 Never M									
	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  College (1-4or 5+)  College (1-4or 5+)  College (1-4or 5+)  College (1-4or 5+)  College (1-4or 5+)  College (1-4or 5+)  College (1-4or 5+)  College (1-4or 5+)  College (1-4or 5+)	,								
S	17. Father's Name (First, Middle, Last)  Lambda Home  And Home  18. Mother's Name (First, Middle, Maiden Surname)									
To Be										
	19a. Informant's Name/Relationship (Type. Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zi	n Code)								
	Norman Kahn - Son 8816 Sundale Drive; Silver Spring, M									
	20a. Method of Disposition  1 X Burial 2 Cremation 3 X Removal from State  20b. Place of Disposition (Name of cemetery, crematory or other place)  20c. Location - City or To									
	21. Signature of Funeral Service Licensee  22. Name and Address of Facility Hines Rinaldi Funeral									
Completed by Physician/Medical Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if a year of the first of t									
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown  23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify)  Month	23d. Date of delivery Month Day Year								
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to									
בופ	Aortic Regurgitation 1 Yes 2 No 3 Prot Renal Insufficiency 24a Was an 24b Was and									
Comp	24a. Was an autopsy performed?  1 □ Yes 2 ☑ No 1 □ Yes	ppsy findings available mpletion of cause of 2 X No								
0	25. Was case referred to medical examiner?  1   Yes 2   No   Hospital:									
	1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Substituting Home 5 ☐ Residence 6 ☐ Other (Specific	5)								
	27. Manner of Death  1 Natural 5 Pending investigation  3 Sulcide 4 Homicide 6 Could not be determined 5 Place of injury - At home, farm, street, factory, office 28c. Injury at Work?  1 Yes 2 No 28d. Describe how injury occurred Work?  1 Yes 2 No 28d. Describe how injury occurred work?  28d. Describe how injury occurred work?  28d. Describe how injury occurred work?  28d. Describe how injury occurred work?  28d. Describe how injury occurred work?									
Medical C	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
IAI	29b. Signature and title of certifier  WM 29c. License number  29d. Date signed (Mon  D0009215  September									
e	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Lawrence D. Marcus MD 10313 Georgia Ave, Suite 207, Silver Spring,  31. Date filed (Month, Day, Year)  SFP 2 5 2007	MD 20902								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2007 32460 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Day 0402AM ne 22 2001 /Medical eptemb 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 5. Social Security Number 218–16–9921 (In yrs. last birthday, If Under 1 Year 8. Date of Birth (Month, Day, Year) **Funeral** Age Birthplace (State or Foreign Country) 1 □ M 2 🕅 F Months Days Hours Min. Yrs. Director 6/18/1926 MDUsual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 28a-f show ms 23a or 28a-f shoren Director 1 XYes 2 No MD Kent Rock Hall 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5698 Walnut St. 21661 Funeral items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2X If Yes, Give Year or Dates: 1 Never Married 2 Married 2X No 5 altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo ģ Specify: Specify: White 3 Widowed 4 Divorced "natural", Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 11 of Health and Mental Hygier

fitem 27 Is marked other the
r other traumatic event, the Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Arthur Coleman မှ Alva Kellev 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a Arthur Kendall/Son PO Box 584 Rock Hall, MD 21661 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Department o Important: If any injury or once. ± ŏ Wesley Chapel Cemetery 9/26/2007 Rock Hall, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Fellows, Helfenbein&Newnam uf 130 Speer Rd. Chestertown, MD 21620 23a. Part1. Enter the disease, or combications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one rause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician END STAGE DEMENTIA 1 month disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Litter Unidentifying Cause (Disease or injury that initiated events Physician/Medical Examiner Due to (or as a consequence of) The law requires that the death certificate be executed and use as the burial-tran resulting in death) Last Due to (or as a consequence of) P.O. Box 68760, attending physician for use as the buria IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 9□Unknown 5 ☐ Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, ģ Parknsons disease 1 ☐ Yes 2 🗖 No 3 🗌 Probably 4 🖂 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☑ No s certificate has t lirector, page 2 s 24a. Was an autopsy perform 2 No 1∐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 25 No Inpatient Other: 2 ER/Outpatient 3 DOA Certification: To 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral di this 27 Manner of Death 28a. Date of Injury (Month, Day 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 16 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0041587 24 D 5 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Chestectour, MD 21620 172 Speer Ect. telen MI Noble

DHMH 17 Rev 1/2001

State

Registrar

s Signature

32. Regis

2007

07-07441 Edward Hugh Kobacker Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2007 32462

		1- For State Certificate of Death	Reg	j. No.				
Physicia	n/	1. Decedent's Name (First, Middle,Last)	2. Date of Death Month		3. Time of Death			
/ledical Examin			Month September		2245 hrs			
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4977 Battery Lane #719 Bethesda	·   11.	4c. County of Dea Montgomery				
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs.  Months Days Hours Min.		(MM/DD/YYYY) 9. E	Birthplace (State or eign			
Director		104-62-0525   1\(\times\) M 2 F   44 Yrs.   Months Days noors   Min.	Dec.10	,1962	Country) N.Y.			
	- 4044	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location	-	74	10d. Inside City Limits			
_ 0M at	- 1	Md Montagmary Bothanda			1 X Yes 2 No			
daryland 28a-f show any 1 at once.	핡	10e. Street and Number 10f. Zip Code	: 10.	g. Citizen of What Co				
death with the Maryland or items 23a or 28a-f sho must be notified at once	E E		. 10	USA	John y:			
h with	era	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto R		14. Race - Am White, etc.	erican Indian, Black,			
	y Funeral		trocking otc.		hite			
ours a atura	g p	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of wo		16b. Kind of Busines	s/Industry			
6 172 hours an "nature	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) during most of working life. DO NOT use retire	ea)	_				
003 within iene. er tha	Ĕ	5+ Realtor		Real Est	ate			
15-( filed I Hyg ed oth								
ID 21215-0036 should be filed within 72 hours after and Mental Hygiene. T is marked other than "natural"; natic event, the Medical Examiner.	To Be	19a. Informant's Name/Relationship (Type, Print )  19b. Mailing Address (Street and Number or Ru			ate Zin Code)			
imore, MD 21215-0036 Pages I and 2 should be filed within nent of Health and Mental Hygiene aut: If item 27 is marked other that or other traumatic event, the Media	-1	Edward J. Kobacker/Father 7 Wexford Club Dr., Hi		-				
- P = E E		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery,	Date	20c. Location - City				
Baltimore, permit. Pages 1 at Department of He Important: If ite		1 Burial 2 X Cremation 3 Removal from State crematory or other place) 4 Donation 5 Other Specify: Metropolitan Crem. Sep.	25,07	Alevand	ria, Va.			
Baltimo permit. <sup>1</sup> Page Department of Important: injury or of	+	21. Signature of Fune Society: Metropolitan Crem. Sep.			IIa, va.			
Balt permit. Depart Impor		have It will 2222 Wisconsin Ave.			DC 20007			
Physician	1	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or failure. List only one cause on each line. Diabetic ketoacidosis complicated by hype Immediate Cause (Final disease a atherosclerotic cardiovascular disease with an	respiratory arre	st, shock, or heart	Approximate Interval Between Onset and			
/Medical taminer		Immediate Cause (Final disease a atherosclerotic cardiovascular disease with an	omalous o	coronary art	ery Death			
2	1	or condition resulting in death)  Due to (or as a consequence of):			=			
	ā	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):						
	튑	cause. Enter Underlying Cause (Disease or injury that initiated	4	, ,				
	Examiner							
760, icate be execute physician and the burial - tran	/Medical	X UNPENDED						
760, ficate be g physici the buri	좕	#23a,27, perME, g872, 10/11/07 TT  IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date of deliv	ery			
687 ertific ding p	au/	23b. Was decedent pregnant in the past 12 months?  1 Live birth 2 Fetal death 3 Ectopic pregnan	су	Month	Day Year			
Box 68 e death certiful the attending	Physiciar	1 Yes 2 No 9 Unknown Pregnant at time of death 5 Other (Specify)						
P.O. Box 68's sthat the death certificated by the attending edetached for use as the control of	影	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tob	acco use contribute	to the cause of death?			
P.O.	<u>(</u>		1 Yes	2 <b>V</b> No 3 P	robably 4 Unknown			
ords, w require	Completed		24a. Was a		autopsy findings available			
cor e law e has t	립		autops	ned? death				
tal Rection: The certificate ector, page		25. Was case referred to medical 26.Place of Death (Check or	1 Yes 2	No 1 🗸	Yes 2 No			
Vital hysician this cert	m	examiner? [Hospital: 4   Inserting 2   FR/Outsetient 3   DOA   Other;   Alice		Residence 6 🗸 Otl	ner: Scene			
Division of Vital Records, rat or Attending Physician: The law requirers after death.  al Director: After this certificate has been sited in by the funeral director, page 2 should be.	앍	27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 2		ow injury occurred				
ion tendin tor: A the fu	<u></u>	1 X Natural 5 Pending (Month, Day,Yeár) 1 Yes 2 No						
Visi or Att fer de hirect in by	ertification:	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. 2			Rural Route Number, City			
Divisipital or Attours after deral Direct filled in by	S S	4 Homicide determined (Specify)	or Town, St	ate)				
9 7 8 - 1	न्न	29a. Certifier (Check only one) 2 Medical Examiner: On the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)						
S S S S S S S S S S S S S S S S S S S	ĕ⊦	29b. Signature and little of certifier 29c. License number		29d. Date signed (A	fonth, Day, Year)			
		O.C.M.E.		September 24,	2007			
OCME	.  -	30. Name and address of person who completed cause of death (Item 23a)						
		Mary G. Ripple MD. Deputy Chief Ledical Examiner 111 Penn Street, Baltimore, MD	21201					
Sta Registr	-							
110001011	-							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Day Richard Gordon Lankford 5, 2007 October | 7:00 A. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 14386 Calvert Street Solomons Calvert 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 7. Age (In vrs. last birthday, **Funeral**  Birthplace (State or Foreign Country) Months Days 1 M 2 □ F Hours 215-52-9723 56 Director 10-19-1950 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show "natural", or items 23a or 28a-f shov edical Examiner must be notified at MD Calvert Solomons 5 Director 1 ☐ Yes 21 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 14386 Calvert Street 20688 United States Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. All Yes 2 No If Yes, Give Year or Dates: Vietnam 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 2 Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed permit. Pages 1 and 2 should be filed within 72 hr
Department of Health and Mental Hygiene.
Important: If Item 27 Is marked other than "natu
any in]ury or other traumatic event, the Medical. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Meat Cutter 12 Retail Food 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Raymond Lankford, Sr. Elizabeth Jane Martin 19a. Informant's Name/Relationship (Type. Print) (Wife) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brenda A. Barretta Lankford 44782 St. Andrews Church Rd; California, MD 20619 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ▼ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 10/05/07 Alexandria, Virginia 21. Signature of Funeral Service Licens 22. Name and Address of Facility Rausch Funeral Home, P.A. P. O. Box 600, Lusby, Maryland 20657 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician Due to (or as a consequence of): /Medical Examiner Sequentially list conditions, if any, leading to infine date cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off Examine or Attending Physician: The law requires that the death certificate be executed physician and the burial-transi Due to (or as a consequence of): Physician/Medical as IF FEMALE: 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the a 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown cate has been si , page 2 should h Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2⊠No certificate 1∐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner's Other: 1 Tes မ 3√2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 27. Manner of Death 28a. Date of Injury 28b. Time of After t 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation Natural (Month, Day Year) Injury To the maspines within 24 hours after death.

To the Funeral Director: Af 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Division or Vital Records, P.O. Box 68760 the Hospital

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Registrar

Medical

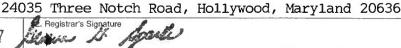
29a. Certifier

(Check only one)

29b. Signature and title of certifier

Nikhil Uppal, MD 31. Date filed (Month, Day, Year) 0CT 1 0 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



and manner stated.

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License numbe

29d. Date signed (Month, Day, Year) October 5, 2007

Division or Vital Records, P.O. Box 68760, or Attending Physician: funeral After ours after death.

neral Director: A
filled in by the fu

Certificate of Death Req. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death LANEY THERESA **Physician** Month 09 139 2007 11:10 pm /Medical 4a. Facility Name,(If not institution, give street and number)
Southern Maryland Hospital 4b. City. Town, or Location of Death Clinton 4c. County of Death Examiner Prince Georges 7. Age (In yrs. last birthday) 87 yrs If Under 1 Year If Under 24 Hrs. 8. Date of Birth 09-06-1920 9. Birthplace (State or Foreign Social Security Number 6. Sex Hours 7-24-4989 Days 1 □ M 2 1 F Yrs. Washington, DC Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location
Temple Hills 10a. State 10b. County 10d. Inside City Limits Prince Georges MD 1 Yes 2 No Director 10g. Citizen of What Country?
USA 10f. Zip Code 20748 10e. Street and Number Carrick Place 6405 Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: Black Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working File Clerk Eiementary/Secondary (0-12) Private College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname)
Gertrude Anderson 17. Father's Name (First, Middle, Last) Be James Chisley 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 6405 Carrick Place Temple Hills, MD 20748 Sharon Hollingsworth Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place Lincoln Cemetery) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ■ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Suitland, MD 09/25/2007 22. Name and Address of Facility Bianchi 814 Upshur St NW Wash, DC 20011 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between Onset and Death Immediate Cause (Final **Physician** Dnyummia disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner HITHEIME Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) signed by the attending physician and d be detached for use as the burial-tran Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ You 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 2 ER/Outpatient 3 DOA 1 patient Certification: To 28a. Date of Injury 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year) ans 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 11701 Livingston Road Fort Washington T. TANNW my 31. Date filed (Month, Day, Year) 32. Registrar's Signature State SEP 2 6 2007 Registrar

# Baltimore, Maryland 21215-0036

For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Vear Andrew Lewish ,2007 September 11:15A 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 2992 HIckory Valley Drive Waldorf Charles 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) Birthplace (State or Foreign Country) Days Hours 11XM 2□F Vrs 061-16-3256 **Director** 86 January 16,1921 New York Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If Item 27 is marked other than "natural", or items 23a or 28a-f show any or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d Inside City Limits 1 ☐ Yes 2 No Directo MD Charles Waldorf 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2992 Hickory Valley Drive Funeral 20601 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Yo Yes 2 □ No If Yes, Give 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2√ No Specify: ò Specify: White 3 Widowed 4 □ Divorced Year or Dates Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Major US Airforce 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Gregory Lewish Tekla Dmytriw 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2625 Tanager Drive, Wilmington, DE 19808 William Lewish/Brother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State Important: If any injury or once, 4 ☐ Donation 5 ☐ Other (Specify) Maple Grove Cemetery 19/28/07 Horseheads, New York 21. Signature of Funeral Service Licenses . Name and Address of Facility AREHART—ECHOLS FUNERAL HOME, P.A. 20646 Mary's Ave. La Plata, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner physician and s the burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical attending ph IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an was a autopsy performed? page 2 s certificate 1☐ Yes To the Hospital or Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 🕅 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 Natural 2 ☐ Accident Injury s after death. 1 TYes 2 □ No 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of certifier 29c. License number moleted caus of death (Item 23a) (Type, Print) 445 M W 31. Date filed (Month, Day, Year) 32. R State SEP 2 5 Registrar 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

State of Maryland / Department of Health and Mental Hygiene 32467 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year September 26 2007 **Physician** 8:02 A M Samuel David Lohman /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery <u>Suburban Hospital</u> Bethesda If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)

Min. March 10,1927 If Under 1 Year 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1**X** M 2□F Days Months Yrs 80 Director 216-22-9685 Usual Residence of Decedent r 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Director Maryland Washington Sharpsburg 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 'natural", or Items 23a or ? dical Examiner must be n Funeral <u> 18009 Burnside Bridge Road</u> 21782 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 194

If Yes, Give Year or Dates: 194 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1944filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 \$ Specify. 3 □ Widowed 4 Divorced White Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry of Health and Mental Hygiene.
If item 27 Is marked other than or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) Mechanic/Welder Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဥ Samuel Howell Lohman Ruth Irene Churchey 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Darlene Churchey - Daughter 18009 Burnside Bridge Road Sharpsburg, Maryland 21782 Department of Health Important: If item 27 any Injury or other tr 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages 1) Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) View Cemetery Oct.1,2007 Sharpsburg, Maryland 21. Signature of Funeral 30 price 0용berned 주변하는 FadlityHome, P.A. 425 S. Conococheague St.Williamsport, MD 21795 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Renal Failure two weeks /Medical Due to (or as a consequence of): Examiner Ischemic Cardiomyopathy 25 years Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Physician/Medical Examine the burial-trar 8:02 am Box 68760, Due to (or as a consequence of) attending physician for use as the buria IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) P.0. 9 Unknown 9 Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Tes 2 No 3 Probably 4 Unknown funeral director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2【 No 24a. Was an autopsy performed? **Division or Vital 2**√□ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending investigation Injury 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours a Funeral ( Medical 29a. Certifier 1 🗶 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Michael a Westiman, M.D. D52451 September 26,2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Michael A. Westerman, M.D. Suburban Hospital 8600 Old Georgetown Rd. Bethesda, MD NOH. 3+1 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

September 26,200

Samue

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 9 Day 23 **Physician** 2007 Betsy Beauchamp Long-Fears 11:30 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner 400 S. Main St. Berlin Worcester If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🔀 F Months Days Hours Min. Director 219-46-4334 71 1/9/1936 MD Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10h. County 28a-f show 1 ☐ Yes 2 No Examiner must be notified Director MD Worcester Berlin 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö **23a** 400 S. Main St. 21811 USA Funeral death v 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specity Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ō 1 ☐ Yes 2 ☑ No Specify: Specify: ģ 3K Widowed 4 ☐ Divorced White Year or Dates "natural" Completed 16a. Decedent's Usual Occupation event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) Health and Mental Hygiene. Owner/Operator Poultry 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Roland W. Beauchamp ပ Margaret Cross Jackson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Item 27 7406 Libertytown Rd., Berlin, MD 21811 Susan J. Todd/ cousin 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If Ite any Injury or ot once. 1 Burial 2 Cremation 3 Removal from State St. Paul's Churchyard 4 Donation 5 Dother (Specify) 9/27/2007 | Berlin, MD 21. Signature of Funer 22. Name and Address of Facility Burbage Funeral Home 108 William St., Berlin, MD 21811 23a. Part I. Enter the disease or complications that a lsed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Immediate Cause (Final disease or condition resulting in death) **Physician** BSCKD EVERALYFARS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): physician a s the burial-1 Division or Vital Records, P.O. Box 68760, Physician/Medical ast IF FEMALE: 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Day 5 ☐ Other (specify) ed by the a detached i 1 ☐ Yes 2 ☐ No. 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown DEMENTIA 24a. Was an Were autopsy findings available prior to completion of cause of has e 2 autopsy performed? Yes 2 No death? 1 ☐ Yes 2 ☐ No After this certificate director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA မ 28a. Date of Injury 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 ☐ Accident 5 ☐ Pending investigation (Month, Day Year) Injury within 24 hours area com. To the Funeral Director: Aft M 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 22 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

DUZOTTHY 31. Date filed (Month, Day, Year) State 25 Registrar

29b. Signature and title of certifier

MORTH Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2007

SNOW St. SNOWHILL MB. 21263

29d. Date signed (Month, Day, Year)

29c. License number

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Year Month **Physician** Janet Elizabeth Lowe September 26,2007 9:02A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Southern Maryland Hospital Center Clinton Prince Georges If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Securify Number 7. Age (In yrs. last birthday **Funeral** Days Hours 1 □ M 2 X F 219-36-9944 Director 65 October 1,1941 Washington DC Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10c. City, Town or Location r 28a-f show notified at 10a. State 10b. County 10d. Inside City Limits Director 1 ☐ Yes 2X☐ No MD Charles Waldorf 10e Street and Number 10f. Zip Code 10g, Citizen of What Country? a or 7935 Bensville Road an "natural", or items 23a Medical Examiner must l 20603 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes ŽŽ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 marked other than matic event, the Me College (1-4or 5+) Retail Clothing 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit, Pages 1 and 2 should be file Department of Health and Mental Hy Important; If Item 27 Is marked other any injury or other traumatic event Clarence Edward Bowling Laura May Payne 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Lowe/Husband 7935 Bensville Rd. Waldorf,MD 20603 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Maryland Veterans Cem. 10/3/07 4 □ Donation 5 □ Other (Specify) Cheltenham, Maryland M00945 21. Signature of Funeral Service Licenses 22. Name and Address of Facility AREHART—ECHOLS FUNERAL HOME, P.A. curl dru 211 St. Mary's Ave. La Plata, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Covees disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, in the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last iner be executed Exami sician and burial-trans physician Physician/Medical the as attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year 4□Pregnant at time of death 5 Other (specify) signed by the a Id be detached f Ö 9 Unknown ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ģ Yes 2 No 3 Probably 4 Unknown Completed Thrombophalehitis 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No has e 2 s page certificate 1 ☐ Yes 2 □ No or Vital : After this certific funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ို 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: Division Hospital or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours a er death,

To the Funeral Director: A
completely filled in by the fu hours a er death, 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1 Pritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 0001923 26 2000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print A Registrar's Signature Y9"2007 State Registrar

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** BETTY MATHEWS OCTOBER 2007 10:40 A M JO /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner FOREST HILL HEALTH & REHAB CENTER FOREST HILL HARFORD If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs, last birthday) Birthplace (State or Foreign Country) 6. Sex Date of Birth (Month, Day, Year) Months Days Hours 1 □ M 2 🔀 F Yrs. 259-36-9892 80 July 9,1927 Georgia Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits 1 ☐ Yes 2 No Directo MD Harford Bel Air 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 606 Cedar Lane 21015 Completed by Funeral U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 ☐XNo 3X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Deli Manager Grocery 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Robert Atchison Naomi Long ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cathy Mooneyham (Daughter) 606 Cedar Lane, Bel Air, MD 21015 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 \ Burial 2 □ Cremation 3 □ Removal from State Harford Mem. Gdns. 4 ☐ Donation 5 ☐ Other (Specify) 10/5/07 Aberdeen, Maryland 21. Signature of Funeral Service Li 22. Name and Address of Facility Tarring-Cargo Funeral Home, Aberdeen, Maryland 21001-3 23a. Part1. Enter the disease, or complication shock, or heart failure. List only one car ds hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, use on each line. Immediate Cause (Final of cerebrations disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Day he cause of death? 4 Unknown bably %Q No

**Physician** /Medical Examiner

physician

permit. Pages 1
Department of H
Important: If ite
any injury or ot

**Funeral** 

Director

r 28a-f show notified at

Pages 1 and 2 should be filed within 72 hours after death with i ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or item vor other traumatic event, the Medical Examiner must be nury or other traumatic event, the Medical Examiner must be no

Baltimore, Maryland 21215-0036

the Maryland

use as the burialattending p for use as been signed by the should be detached certificate ha funeral director. s after death.

I Director: A

To the Hospital or Attending Physician: The law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760,

Medical Certification: To Be Completed by Physician/Medical Examiner

resulting in death) cast	Due to (or as a consec	quence of):			
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf pregn 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of o	al death 3 □Ectopic			23d. Date of delivery Month Day Year
Part II. Other significant conditions of	ontributing to death but not res	sulting in the underlying	cause given in Part I.		use contribute to the cause of death
say tulie for	ectum			24a. Was an autopsy performed? 1∐ Yes 2 ⊠N	
25. Was case referred to medical examiner?			26. Place of De	ath (Check only one)	
1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐	]ER/Outpatient 3 ☐ I	OOA Other: Nursing	Home 5 Residence	6 ☐Other (Specify)
27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how inju	ury occurred
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At h building, etc. (Special	ome, farm, street, factory)	ory, office	28f. Location (Street a City or Town, Sta	and Number or Rural Route Number, te)
29a. Certifier Certifying Ph	ysician: To the best of my kno	owledge, death occurre	ed at the time, date and place	e, and due to the cause(	s) and manner as stated.

State Registrar 31. Date filed (Month, Day, Year) OCT 1 0 2007

DAVID DUNN

29b. Signature and title of certifier



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

within 24 hours a

29c. License number

2250

BEL AIR, MD.

21014

29d. Date signed (Month. Dav. Year)

2007

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day SOPHIA JEAN MONTERO-GERBEN 10:31 pm M DEPTEMBER 2007 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death 13 Johns Hinking BANVIEW Medical AltiMore If Under 1 Year | If Under 24 Hrs. Months | Davs | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex 8. Date of Birth (Month, Day, Year) Months 1 □ M 2 🖸 F N/A 9/28/2007 Maryland Usual Residence of Decedent 10c, City, Town or Location 10b. County 10d. Inside City Limits MD Baltimore Baltimore 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1909 Adams Road 21222 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 【XNo Specify Specify: White 3 Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) N/A N/A N/A 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles Michael Gerben Jessica Ruth Montero 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles Michael Gerben/Father 1909 Adams Road, Baltimore, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Evans Eagle Crematory 10/3/2007 4 □ Donation 5 □ Other (Specify) Leola, PA 21. Signatur of Funeral Service 22. Name and Address of Facility Harkins Funeral Home, Inc., Delta, PA 17314 ations that caused the dean. Do not enter the mode of dying, such as cardiac or respiratory arrest, cause on each line. Part1. Toker the disea shock, or heart failure Immediate Cause (Final W LAMONIU 10 hours disease or condition resulting in death) Due to (or as a consequence of) Alter.osus Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Year 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? 27 No 1 🗌 Yes 3 Probably 4 Unknown

**Physician** /Medical Examiner

the death certificate be executed

P.O. Box 68760,

Division or Vital Records,

Department of H Important: If ite any injury or ot

**Physician** 

/Medical

Examiner

10a, State

**Funeral** 

Director

ral", or items 23a or 28a-f shov Examiner must be notified at

other traumatic event, the Medical

e filed within 72 hours after death val Hygiene.

Pages 1 and 2 should be file tment of Health and Mental Hi tant: If item 27 is marked oth

altimore, Maryland 21215-0036

Director

Funeral

Completed by

Be

Examine physician and s the burial-trans use as for signed by the a 2 has r page

Physician/Medical Be Completed Certification: To To the Hospital or Attendi within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24b. Were autopsy findings available prior to completion of cause of death? autopsy / performed?

			1☑ Yes 2☑ No 1 ☐ Yes 2☑ No
25. Was case referred to medical examiner?		26. Place of Death	(Check only one)
1 Yes 2 No	Hospital: 1 Inpatient 2 ER/Outpatient 3	□ DOA Other: 4 □ Nursing Hom	ne 5 Residence 6 Other (Specify)
27. Manner of Death  1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigatio		Work?	8d. Describe how injury occurred
3 Suicide 6 Could not b 4 Homicide determined		actory, office 28	8f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier 1 Certifying Pi	hysician: To the best of my knowledge, death occ	urred at the time, date and place, a	nd due to the cause(s) and manner as stated.

	one)	<i>y</i>
29b.	Signature	an

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. d title of certifier 29d. Date signed (Month, Day, Year)

1/2	5	MO			
30. Name and address of	f person who co	mpleted cause of	death (Item	23a) (Type,	Print)

29c. License number 63911

SEPTEMBER 30, 2007

3

State Registrar

Br.AN Stone MD 31. Date filed (Month, Day, Year)

4940 FASTES AVENUE 32. Registrar's Şignature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician**  $P^{M}$ 2007 Dorothy Belle Mann October 0 1310 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Union Hospital Cecil E1kton If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, May 12, Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Funeral Months Days Hours Min. 1 □ M 2 🕅 F 1930 Mary 1and 77 Director 219-28-0900 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City. Town or Location 10d. inside City Limits 10b. County 1 Yes 2 □ No Director Mary1and Cecil. E1kton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 326 West Main Street 21921 United States by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Assembler Medical Products 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Melvin Murson Mary Ellen Hopkins 19b. Mailing Address (Street and Number or Rural Route Number, Cify or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Leonard L. Mann/Husband 326 W. Main Street, Elkton, Maryland 21921 20b. Place of Disposition (Name of cemetery, crematory or other place)
Gilpin Manor 20a. Method of Disposition Date 20c. Location - City or Town, State October 5, 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Ponation 5 ☐ Other (Specify) 2007 Elkton, Maryland Memorial Park Hicks Home for Funerals, P.A. 103 W. Stockton Street, Elkton, Maryland 21921 ture of Funeral Service Licensee 21. Signa 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): **Examiner** Myecardia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine ntrab domi burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a g Unknown 9 Unknown cate has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐XNo 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No autopsy tai 2 **N**lo 1∐ Yes Hospital or Attending Physician: funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No ပို 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 X Natural 2 ☐ Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No hours after death uneral Director: 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral I 29a. Certifier 1 👺 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie 29d. Date signed, (Month, Day, Year) 65902 mo Carlo E. Gopez, M.D. 10 2192 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 1/2001

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31. Date filed (Non

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32- Registrar's Signature

ElKton

		,	1- State Registrar Amend Item 24 a per Maryland 73 Penagrapa Amend Item 24 a per Maryland 73 Penagrapa Amend Item 24 a per Maryland 73 Penagrapa Amend Item 24 a per Maryland 73 Penagrapa Amend Item 24 a per Maryland 73 Penagrapa Amend Item 24 a per Maryland 73 Penagrapa Amend Item 24 a per Maryland 73 Penagrapa Amend Item 24 a per Maryland 73 Penagrapa Amend Item 24 a per Maryland 73 Penagrapa Amend Item 24 a per Maryland 73 Penagrapa Amend Item 24 a per Maryland 73 Penagrapa Amend Item 24 a per Maryland 73 Penagrapa Amend Item 24 a per Maryland 73 Penagrapa Amend Item 24 a per Maryland 73 Penagrapa Amend Item 24 a per Maryland 73 Penagrapa Amend Item 24 a per Maryland 73 Penagrapa Amend Item 24 a per Maryland 73 Penagrapa Amend Item 24 a per Maryland 73 Penagrapa Amend Item 24 a per Maryland 73 Penagrapa Amend Item 24 a penagrapa Amend Item 24 a penagrapa Amend Item 24 a penagrapa Amend Item 24 a penagrapa Amend Item 24 a penagrapa Amend Item 24 a penagrapa Amend Item 24 a penagrapa Amend Item 24 a penagrapa Amend Item 24 a penagrapa Amend Item 24 a penagrapa Amend Item 25 a penagrapa Amend Item 26 a penagrapa Amend I	Mental Hyو ا	giene Reg. No. 200	7 32473
	Physici	an	1. Decedent's Name (First, Middle, Last)	2. Date of Dea	ath Day Yea	3. Time of Death
1	/Medic		Elsie S. Morrison	Sept	24 200	7  12:50 A <sup>M</sup>
?	Examin	er	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 5208 Tilden Road Bladensburg		4c. County of De	George's
	Funeral	N.C.	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	8. Date of Birt	h 9. B	irthplace (State or Foreign
	Director		220-38-1595 1□ M 2▼ F 94 Yrs. Months Days Hours Min.	Feb 20		nnsylvania
	w		Usual Residence of Decedent  10a. State 10b, County 10c. City, Town or Location			10d. Inside City Limits
	Maryla	lor	MD Prince George's Bladensburg			1 ☑ Yes 2 ☐ No
	n the	Director	10e. Street and Number 10f. Zip Code		10g. Citizen of What (	Country?
	ith wit 23a o ust be	a D	5208 Tilden Road 20710		USA	
	er dea Items ner m	Funeral	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispanic Origin? (Sp. 14 Marital Status)  14. Was Decedent Ever in U.S. Armed Forces?  15. Was Decedent of Hispanic Origin? (Sp. 14 Marital Status)	pecify Yes or No- pecify Yes or No- pecify Yes or No-	. 14. Race - An Black, Wh	nerican Indian, nite, etc.
39	ırs aft al', or xami	by	1 □ Never Married 2 □ Married 1 □ Yes 2 ☑ No If Yes, Give 1 □ Yes 2 ☑ No Specify: 3 ☑ Wildowed 4 □ Divorced Year or Dates:		Specify: C	aucasian
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an	should be filed within 72 hours after death with the Maryland and Mental Hygiene. I warked other than "natural", or Items 23a or 28a-f show umatic event, the Medical Examiner must be notified at	To Be		nna Schi	,	
Maryland	shou and N is mar	_	19a. Informant's Name/Relationship (Type. Print)  19b. Mailing Address (Street and Number or Ru	ral Route Numbe	er, City or Town, State	, Zip Code)
	s 1 and 2. of Health a item 27 is		William Morrison/Son 4210 51st Street, B1			710
20	ages 1 tr of H : If ite		20a. Method of Disposition  1⊠ Burial 2 □ Cremation 3 □ Removal from State  4□ Donation 5 □ Other (Specify)  20b. Place of Disposition (Name of cemetery, crematory or other place)  Fort Lincoln Cemetery Sept	27 - 2007	20c. Location - City of Rrentwood.	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notifiled at once.		4 □ Donation 5 □ Other (Specify) FOR LITICOTH Centetery Sept.  21. Signature of Funeral Service Licensee 22. Name and Address of Facility		39 Baltimo	
ä	Dep Impa any		Molanitan 10/3/73 Gasch's Funeral Hor	ne, PAHy	yattsville	, MD 20781
			23a. Part1. Enter the disease, or compilications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.			Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)  a. AORTIC STEWOSIS			Onset and Death
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ds,	uires l signe Id be	d by	CARDIOMYOPATHY	1 🗆 🗅		Probably 4 □Unknown
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on	th. :: After	tion	27. Manner of Death  28a. Date of Injury  (Month, Day Year)  28b. Time of Injury  28c. Injury at Work?  1 Accident investigation  M 1 Yes 2 No	zou. Describe i	low injury occurred	
N N	r Atter er dea rector by the	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (S	Street and Number or vn. State)	Rural Route Number,
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	To the Hospital or Attending Physician: The law requires that the death certification 24 hours after death.  To the Funeral Director: After this certificate has been signed by the aftending completely filled in by the funeral director, page 2 should be detached for use as	Medical	29a. Certifier (Check only one)  1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place			
	To the I within 2 To the Complet	Me	29b. Signature and title of certifier 29c. License number		29d. Date signed <i>(M</i> o	nth, Day, Year)
			D2828		SEPT. 2	5,2007
1	-(5)		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NELSON BENJERS 913) PISLATAWAY PD, CLIN	M , HOT	9 207	-3.5
	Sta Registr		NELSON BENJERS 913) PISLATANTY PD, CLIN 31. Date filed (Month, Day, Year) SEP 2 6 2007 Security D. September 1.			
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State of Maryland / Department of Health and Mental Hygiene 7 0 7 3

			1 State Registrar		Ce	rtificate of	Death	R	2 U U /	32414
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j.	Examin	er	4a. Facility Name (If not institution, give	•			r Location of Death		4c. County of Dea	
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	aryla show dat	-	10a. State 10b. County  Maryland Prince	Georges	•	1 Heights	,			10d. Inside City Limits 1 🙀 Yes 2 □ No
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3	3a or 3	I Dir	10e. Street and Number 729 Carrington P3	lace		2074	3		10g. Citizen of What Co United S	
	ms 2	Funeral	11. Marital Status	12, Was Decedent Ever i	n U.S. 13.	Was Decedent of H		pecify Yes or No-		erican Indian,
330	72 hours after death with the Maryland hatural", or items 23a or 28a-f show dical Examiner must be notified at	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		1 ☐ Yes 2 ☐ No	Specify:	o Fican, etc.)	Black, Whi	
2-0036	"natura	Completed	15. Decedent's Ed (Specify only highest gra	lucation de completed)	16a. Dece	edent's Usual Occup e kind of work done of DO NOT use retired	ation during most of wor	king	16b. Kind of Business	/Industry
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י ס	Hygid Hygid Sther Sint, tl	ပ္တို	17. Father's Name (First, Middle, Last)			0. 102200		ne (First, Middle,	Maiden Surname)	
and	d be ental ked o	To Be	William Dudley				Maggie	Dudley		
<u> </u>	shou nd M mar	-	19a. Informant's Name/Relationship (	Type. Print)	19b. Maili	ing Address (Street	and Number or Ru	ıral Route Numbe	r, City or Town, State,	Zip Code)
ž :	and 2 salth a 27 is er trai		Reginald A. Mile		1	S. Southwe		Annapol:	is, Md. 21	1401
baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If frem 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1	nemoval from State		osition (Name of ematory or other place Veterans		.26, 2007	20c. Location - City or Cheltenha	,
סמונו	permit. Departr Importa any Inju		21. Signature of Funeral Service Licer	Muse MI	X085 2	2. Name and Addre ATEXANDE 5538 Mar	ss of EacilityPop Iboro Pi	kė/Forės	tville, Md	. 20747
Н	1000		23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the cone cause on each line.	leath. Do not en	ter the mode of dyir	ng, such as cardiad	or respiratory an	rest,	Approximate Interval Between
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	sician: The law requires that the death ce certificate has been signed by the attendi rector, page 2 should be detached for use	Physician/	in the past 12-months? 1 □ Yes 2 ☑ No 9 □ Unknown	4□Pregnant at time 9□Unknown		Other (specify)			Month	Day Year
Γ.	that the control of t		Part II. Other significant conditions of	ontributing to death but not	resulting in the u	ınderlying cause giv	en in Part I.	23e. Did to	bacco use contribute t	o the cause of death?
records,	requires that the een signed by the ould be detache	d by						1 🗆 Y	'es 2 No 3 P	robably 4 Dunknown
	s beer	lete						24a. Was a	an 24b. Were a	utopsy findings available
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>	nysic his ce i direc	ToE	1 Yes 2 No		2 ☐ ER/Outpatie	nt 3□ DOA Oth	er: 4 Nursing H	lome 5⊠ Resid	ence 6 □Other (Spe	ecify)
	Ing P		27. Manner of Death 1 → Natural 5 → Pending	28a. Date of Injury (Month, Day Yea	r) 28b. Time o	Wor		28d. Describe h	ow injury occurred	
VISION	tend leath. tor: / the fi	cati	2 Accident investigation 3 Suicide 6 Could not be		At home form st		Yes 2 □ No	OOA Leastine (C	Annahan di Abumbanan T	Devide March and
	al or Al s after o al Direc	Certification:	4 ☐ Homicide determined	28e. Place of injury - A building, etc. (Sp.	ecify)	reet, factory, office		City or Tow	treet and Number or F n, State)	lurai Houte Number,
:	To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate he completely filled in by the funeral director, page	edical (	29a. Certifier 1 XCertifying Ph (Check only one) 2 Medical Exar	ysician: To the best of my niner: On the basis of exar and manner stated.	knowledge, dea nination and/or i	th occurred at the time nvestigation, in my convention	me, date and place opinion, death occu	e, and due to the durred at the time,	cause(s) and manner a date and place, and du	s stated. le to the cause(s)
	ro the within Fo the complete t	Me	29b. Signature and title of certifier	11		29c. Licens	e number	- 2	29d. Date signed (Mon	th, Day, Year)
			I were	M	Y	MD	5670	9 s	eptember 25	5, 2007
2	(5)		30. Name and address of person who	completed cause of death	Item 23a) (Type	, Print)	, ,			
	V		Enrique A. Rob			g St., NW	, Washing	gton, DC	20010	
	Sta	ite	31. Date filed (Month, Day, Year)	32. Registrar's S	nature					

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Helen Μ. Martinez September 23, 2007 12:54 P 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Montgomery Casev House Rockville If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Nov. 11, 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days Hours Min 1 □ M 2√D F England 155-34-7818 61 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 No Maryland Montgomery Gaithersburg 10f, Zip Code 10g. Citizen of What Country? 10e Street and Number 20879 USA 19117 Peach Blossom Ct. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🛛 No If Yes, Give Year or Dates: 1 Never Married 2 Married White 1 ☐ Yes 2 🛣 No Specify: Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker In Home 18. Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First, Middle, Last) Edward Robert Bender Maureen Smith 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joseph A. Martinez — Husband 5740 Bay Side Rd., Virginia Beach, VA 23455 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □Removal from State 9/28/2007 All Souls Cemetery Germantown, MD 4 ☐ Donation \_ 5 ☐ Other (Specify) 22. Name and Address of Facility George P. Kalas Funeral Home PA 21. Signature Funeral Service Licensee al 6160 Oxon Hill Road Oxon Hill, Maryland 23a. Part1. Enfort he disease, or complications that, aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) LUNG CANCER Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underl, in Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c If was outcome of pregnancy 23d. Date of delivery oic pregnancy Month Day Year r (specify) ing cause given in Part I 23e Did tohacco use contribute to the cause of death?

**Physician** /Medical Examiner

**Physician** 

/Medical

**Examiner** 

**Funeral** 

Director

'natural", or items 23a or 28a-f show dical Examiner must be notified at

Director

Funeral

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Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natu any injury or other traumatic event, the Medical

Baltimore, Maryland 21215-0036

Physician/Medical þ Completed Be

Certification: To

Medical

Examiner

and as the burial-tra aftending physician as been signed by 2 should be detac has page, certificate funeral director, this after death

Attending Physician: The law requires that the death certificate be executed

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Division or Vital Records, P.O. Box 68760,

in the past 12 months?  1 ☐ Yes 2 ☒ No 9 ☐ Unknown	1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 □Ectop 5 □ Othe
art II. Other significant condition:	s contributing to death but not resulting in t	he underlyi

Tare II. Outor significant contamono o	orning to doder but not resulting in the	anidonying dadoo giron iir i airii		
			1   Yes 2	No 3 Probably 4 ©Unknown
			24a. Was an autopsy performed? 1  Yes 2  No	24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No
25. Was case referred to medical		26. Place of Dea	th (Check only one)	
examiner? 1 ☐ Yes 2 <b>∑X</b> No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpati	ent 3 DOA Other: 4 Nursing H	ome 5□Residence 6	Mother (Specify) Hospice
27. Manner of Death  1 ☒ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year) 28b. Time	of 28c. Injury at Work?	28d. Describe how injury	occurred

1 ☐ Yes 2 📆 🔥	10	1 ☐ Inpatie	nt 2	]ER/Outpatient	3 🗆 [	DOA Other: 4	□ Nursing H	ome 5 Residence	6 Dother (Specify)	Hospic
Manner of Death 1 ☑ Natural 2 ☐ Accident	5 Pending investigation			28b. Time of Injury	M	28c. Injury at Work? 1 ☐ Yes	2 □ No	28d. Describe how inju	ury occurred	
3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined		ury - At h	nome, farm, stree	t, facto	ory, office		28f. Location (Street a City or Town, Sta	and Number or Rural F te)	Route Number

29a. Certifier 1 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check o. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated.

29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D 0064615 September 23, 2007

30. If me and address of person who completed cause of death (Item 23a) (Type, Print) Wroboewski MD 6001 Muncaster Mill Rd. Rockville, Maryland Genevieve

Registrar

filled in by

within 24 hours a To the Funeral

31. Date filed (Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 32476 Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** Elizabeth Newton McWhorter 11:10 P M 19 2007 Sept /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Chevy Chase 9009 Kensington Parkway Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral 1 ☐ M 2 🛛 F 577-03-7433 06-11-1906 Director 101 Washington, DC Usual Residence of Decedent ould be filed within 72 hours after death with the Maryland Mental Hygiene. 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 10a. State 10b. County Centreville 1X Yes 2 No Fairfax Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ns 23a or must be r 5615 Pickwick Road 20120 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, "natural", or items 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White 2 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry the Medical al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Western Union Switchboard Operator 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked 1 any injury or other traumatic ew once. is marked Nellie G. Jett Edward Newton 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9009 Kensington Pkwy, Chevy Chase, MD 20815 Randolph Newton/Nephew 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln Cemetery 09-25-07 Brentwood, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 4739 Baltimore Avenue Richelle Gasch's Funeral Home, P.A. Hyattsville, MD 20781 M01491 23a. Part1. Enter the disease, or compiler tions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Congestive Heart Failure disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Aortic Stenosis Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine sician and burial-transit death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: . If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown been si should I Completed 24a. Was an autopsy 24b. Were autopsy findings available prior to completion of cause of ate has I page 2 s performed? death? 1 □ Yes 2 No 2K No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 SOther (Specify)Residence Hospital: 2N No 1 Inpatient 1 ☐ Yes 2 ER/Outpatient 3 DOA 2 this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Injury at Work? Certification: After or Attending Injury 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No thours after death. Funeral Director; A ely filled in by the fu death. М 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier 1 🖰 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0101028949 The R Jens mos 412567 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Kerry Lewis, 10560 Main Street, #210, Fairfax, Virginia 32. Registrar's Signature 31. Date filed (Month, Day, Year) State SEP 2 6 2007 B. Registrar

State Registrar

			1 - For State Registrar	State of	Marylan		artmen rtificat			and M	lental Hy	giene Reg. No.	107	324	78
ı	Physici		Decedent's Name (First, Middle     Mary	C.	P	McGinn:	is				2. Date of Dea Month September		00 <sup>Year</sup>	3. Time of De 9:49P	ath M
	/Medio Examir		4a. Facility Name (If not institution					Town, or	Location of	of Death			nty of Death	20.102	
			Charles County Nur					P1ata					rles		
	Funeral Director		5. Social Security Number 578–12–4559	6. Sex 7 1 ☐ M 2 ☒ F	. Age (In yrs. 9 <u>5</u>	, ,	If Under Months	Days	If Under Hours	Min.	8. Date of Birt July 22	<sup>h</sup> 1 <b>9</b> 12	9. Birth	place (State or Fe htry) erland	oreign
			Usual Residence of Decedent										DWILL	SI TERILI	
	show	2	10a. State 10b. County Maryland Charle			y, Town or Lo uite Pla							1	1 ☐ Yes 2	
	28a-f	rect	10e. Street and Number	3	WI	iite ria	10f. Zio	Code				10g. Citizen o	of What Cour		
	h with	al Di	4025 Tahoe Place					2069	95			_	USA	, .	
36	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Heath and Mental Hygiene. Important: If Item 27 is marked other than "naturel", or Items 23a or 28a-f show any Injury or other traumatic event, It's Modical Examinar must be notified at once.	by Funeral Director	11. Marital Status  1 ☐ Never Married 2 ☐ Marriad 3 ☑ Widowed 4 ☐ Divorced	If Yes Give		.S. 13.	Was Deced If Yes, spec 1 ☐ Yes		spanic Ori n, Mexican Specify:	gin? (Spe i, Puerto	ecify Yes or No- Rican, etc.)	- 14. R B	lace - Americ lack, White, cify:		
2-0	72 hou	Completed		it's Education st grade completed)		16a. Dece	dent's Usua	al Occupa	ation	t of work	na	16b. Kind of	Business/In	dustry	
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<u>la</u> n	vid be Mental irked itic ev	To Be	William	Ghelmini						Ne1	lie S	zazerbat	ta		
<b>dan</b>	2 sho and 1 is ma		19a. Informant's Name/Relations	,	1 .						I Route Numbe	-		Code)	
ė,	1 and Health em 27		Jennifer R. Knod	e / Granddaug	20b. P	lace of Dispo	sition (Nan	ne of			ins, Mary	Land 2	20695 n - City or To	own State	-
Ď	Sages ent of nt: If It ry or o		1 X Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		ate C	emetery, crer Cedar H	natory`or o	ther place			/2007		nd, Mar		
Baltimore, Maryland 21215-0036	permit. I Departm Importa any Inju		21. Signature of all Service		um	22	. Name an	d Addres	s of Facilit	y Geo	rge P. Ka on Hill,	las Fune	eral Hor		
E	Physician		23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition	only one cause on eac	used the stati th line.				g, such as	cardiac c	r respiratory ar	rest,		Approximate Interval Betwee Onset and Dea	en ith
ı	/Medical Examiner		resulting in death)  Sequentially list conditions	At	as a consequerial F	ibrillat	ion								
	led sit	niner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		as a consequent										
8760,	cate be executed obysicien and the burial-transit	al Examiner	that initiated events resulting in death) Last	c	as a conseq										
687	ntificate ng phys as the	Aedical	IS SEAM S	d				-							
P.O. Box	The law requires that the death certificate be executed as been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown		h 2 ∏ Feta nt at time of de	Ideath 3□	Ectopic pr Other (sp						Date of delive Month	ery Day Year	r
rds, P	w requires that the de been signed by the should be detached	۵	Part II. Other significant condition G.I. B		th but not res	ulting in the u	nderlying ca	ause give	n in Part I.					ne cause of death	
Division of Vital Records,	Physician: The law re this certificete has bee ral director, page 2 sho	Completed									24a. Was a autop perfor	sy	prior to cor death?	psy findings avai nptetion of causi 2 No	llable e of
Z E	Attending Physician: r death. ector: After this certifice by the funeral director, g	Be	25. Was case referred to medical examiner?	Hoepital:				04.			(Check only or	ne)			
<u>5</u>	Phys	2	1 ☐ Yes 2 ☒️No 27. Manner of Death	28a. Date of (Month,	atient 2 🗌	ER/Outpatien 28b. Time of			4 t Nu		ne 5 Resid			/)	
<u>o</u>	tending Ph feath. tor: After th the funeral	atlor	1 ☑Natural 5 ☐ Pendin 2 ☐ Accident investig		Day Year)	Injury	м	8c. Injury Work 1 □ Y	? ′es 2 □ !			ow injury out			
DIVIS	tel or Attenders after death all Director:	Certification:	3 ☐ Suicide 6 ☐ Could a determ	ined 289. Place of	Injury - At ho , etc. (Specify	ome, farm, str	eet, factory	, office			28f. Location (S City or Tow	treet and Nur n, State)	mber or Rura	l Route Number,	
	To the Hospitel or At within 24 hours after o To the Funeral Direct completely filled in by	edical	one)	ng Physician: To the be Examiner: On the basi and manner	is of examinal	wledge, death tion and/or in	estigation,	in my op	inion, deat	d place, a h occurre	and due to the co	ause(s) and r date and place	manner as st e, and due to	ated. the cause(s)	
	To To	Σ	29b. Signature and title of certifie	1/1/-	10		(	License 000616			2	29d. Date sign			
)	TO		30. Name and address of person		1D	23a) /Tuna						Septem	iber 24,	2007	
-	(6)				embrooke			Waldo	orf, Ma	aryla:	nd				
	Sta Registra		31. Date filed (Month, Day, Year) SFP 2 6 2007	22 Dag	istrar's Signa	tura									
	1000011	1	CED 3 R ZUU!	Title a	1. NOT										

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Vear **Physician** Roland G. Mack, Sr. Sept. 2007 4:37 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 6504 9th Avenue Hyattsville Prince George's 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. 6. Sex Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday, **Funeral** Days Months 1 M 2 □ F 14, 61 Dec. Director 579-58-9772 1945 Virginia Usual Residence of Decedent 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits r 28a-f show notified at show Director 1 Yes 2 No MD Prince George's Hyattsville 10g. Citizen of What Country? 10e. Street and Numbe 10f. Zip Code r than "natural", or items 23a or the Medical Examiner must be 20783 Funeral 6504 9th Avenue U.S. death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene.
ant: If Item 27 Is marked other than "natural", or ite 1 ☑ Yes 2☐ No If Yes, Give 1970-76 Year or Dates: 1 ☐ Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify 2 Specify: Black 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) 5+ Certified Public Accountant Self Employed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be h and Mental h ဂ္ Garnette Mack Susanna Gayle 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: if Item 27 is any injury or other trau Jean Mack Spouse 6504 9th Ave. Hyattsville, MD 20783 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Chesapeake Crematory Sep. 24,2007 Beltsville, MD 22. Name and Address of Facility McGuire Funeral Service, Inc. 21. Signature of Funeral Service Lic yune 7400 Georgia Ave., N.W. Washington, D.C. 20012 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Pancreatic Cancer /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Dav Year 4□Pregnant at time of death P.O. I 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Onknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an certificate has treetor, page 2 s autopsy perform 1□ Yes 2 **1** No or Attending Physician: director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 27. Manner of Death funeral 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 5 Pending investigation ours after death.

neral Director: A
filled in by the fu 2 Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital
within 24 hours a
To the Funeral Hospitai Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) un D59607 WIS 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ramin Farbound 1160 Varnum St., N.E. Washington, D.C. 20017 31. Date filed (Month, Day, Year) egistrar's Signature State SEP 25 2007 Registrar

			State of State Property 1 - State State of Sta	Maryland / De	epartment of H Certificate of I		lental Hygie Beo	ne 2007	32480
			Decedent's Name (First, Middle, Last)	-			2. Date of Death		3. Time of Death
	Physicia Medic		David L. Mushinsky				Month September	r 12, 200	7 12:34 P. <sup>M</sup>
	Examin		4a. Facility Name (If not institution, give street and number	per)	4b. City, Town, or	Location of Death		4c. County of Deat	h
Age.			11824 Beekman Place		Potom			Montgor	
	Funeral		1 DM 2 DE	. Age (In yrs, last birtho	Months   Davs	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y	'ea <i>r)   C</i> o	hplace (State or Foreign
L	Director		579-50-4521 X X Z	66 **s	.		Sept. 1	1, 1941 \	Vash. D. C.
yland	at		10a. State 10b. County	10c. City, Town o	r Location				10d. Inside City Limits
Mar	a-f sh ified	ţċ	Florida Broward	Fort La	uderdale				1 ∏Yes 2 ☐ No X
th the	or 28 e not	Director	10e. Street and Number		10f. Zip Code		100	. Citizen of What Co	ountry?
ath w	23a lust b	la l	700 N.E. 16th Terrace		33304			U.S.A.	
<b>3-UUSO</b> 72 hours after death with the Maryland	Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status  1	[XNo	13. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ※ No	lispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit Specify: W	e, etc.
2 hou	natura ical E		15. Decedent's Education (Specify only highest grade completed)	16a. Do	ecedent's Usual Occup	ation	ing 16	6b. Kind of Business	Industry
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and d be filt	ad oth even	Be	17. Father's Name (First, Middle, Last)			Goldie	e (First, Middle, Ma	uden Surname)	
blood Ploud	d Mer narke natic	မ	Abraham Mushinsky  19a. Informant's Name/Relationship (Type. Print)	19b N	lailing Address (Street			City or Town State	Zin Code)
Man Man	Ith an 27 Is I		Allen H. Mushinsky - Bro		324 Beekman				20854
s - g	f Hea item 2 other		20a. Method of Disposition	20b. Place of D	isposition (Name of crematory or other place	re)	Date 20	c. Location - City or	Town, State
<b>SAILIMO</b> sermit. Pages	urtment o rrtant: If njury or		1 M Burial 2 □ Cremation 3 M Removal from S 4 □ Donation 5 □ Other (Specify)  21, Signature of Funeral Service License	ate	vid Mem. G	dns 9/16			cch, Virginia
berri Da	Depar Impor any ir once,		Sonald C. Stotal	myez_	22 Name and Addre Edward Sag 1091 Rockv	el Funera ille Pike	l Direct: , Rockvi	ion, Inc. lle, Mary	
			23a. Part1. Enter the disease, or complications that ca shock, or heart failure. List only one cause on ea	used the death. Do not ch line.	enter the mode of dyir	ng, such as cardiac	or respiratory arres	t,	Approximate Interval Between Onset and Death
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at the de	by the a tached f	Physician/M	1 ☐ Yes 2 ☐ No 4 ☐ Pregna 9 ☐ Unknown 9 ☐ Unknow	nt at time of death vn	5 ☐ Other (specify) _				
COLOS, 1 w requires tha	in signed uld be de	þ	Part II. Other significant conditions contributing to dea	th but not resulting in th	ne underlying cause giv	en in Part I.			o the cause of death? robably 4  ☐Unknown
Teco	e has bee age 2 sho	Completed					24a. Was an autopsy perform	prior to	utopsy findings available completion of cause of
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Ir V	nis ce direc	To E	examiner? 1 Yes 2 No Hospital: 1 In	patient 2 ☐ ER/Outpa	atient 3□ DOA Oth	er: 4 🗆 Nursing He	ome <del>5 X Rosiden</del>	Brother (Spe	s residence
OLI OLI	th. : After the funeral		27. Manner of Death  1 Natural 5 Pending (Month) 2 Accident investigation	Injury 28b. Tin , <i>Day Year)</i> Inju	ıry Wor	yat k? Yes 2 □ No	28d. Describe how	injury occurred	
JIVISION or Attending	after dea Director	Certification:	3 Suicide 6 Could not be 4 Homicide determined 28e. Place 6 buildin	of injury - At home, farm g, etc. <i>(Specify)</i>	n, street, factory, office		28f. Location (Stre City or Town,	et and Number or R State)	ural Route Number,
e Hospita	within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as	Medical C	29a. Certifler (Check only one)  1 X Certifying Physician: To the ba and manna	sis of examination and/					
To th	within <b>To th</b> comp	Me	29b. Signature and tile of certifier		29c. Licens	se number	290	d. Date signed (Mon	th, Day, Year)
9	20		1 Deral Mil	m	D35	5579	Se	ptember 1	3, 2007
0	~~		30. Name and address of person who completed cause		pe, Print)			•	
			Susan J. Miller, M. D.		p Hill Term	cace, Bet	nesda, Ma	ryland 2	0816
	Sta Registi		31. Date filed (Month, Day, Year) SEP 2 5 2007	gistrar's Signature	Sparte				

			1 - For State Registrar	State of Ma	aryland / Depa <i>Cei</i>	artment of H <i>rtificate of L</i>		Mental Hy	gien 0	07	324	81
	Physic		Decedent's Name (First, Middle, Last)  Valerie Mar	garot Mod	100			2. Date of De Month	path Day Der 19,	Year	3. Time of	
	/Medi Examir		4a. Facility Name (If not institution, give s		ses	4b. City, Town, or	Location of Deat	<del>-</del>		ty of Death	3:25	A M
		Ш	William Hill Manor		(I	Easton	If I Indox 04 Uzo		Talb			
Ī	Funeral Director		5. Social Security Number 6. Sex 187–38–9599		(In yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bi (Month, Da Feb. 22	ay, Year)	9. Birthpl Coun New		· Foreign
	/land		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or Lo	cation		· · · · · · · · · · · · · · · · · · ·		10	d. Inside Cit	y Limits
	e Many ta-f sh tiffed	ctor	Maryland Talbot		Easton						1 ☐ Yes	XX
	with th	Funeral Director	10e. Street and Number			10f. Zip Code			10g. Citizen o		•	
	death ms 23	erai	545 Cynwood Drive  11. Marital Status 1	2. Was Decedent E		21601 Was Decedent of Hi	spanic Origin? (S	pecify Yes or No	United 14. Ra	State		
36	be filed within 72 hours after death with the Maryland nat Hygiene. ad other than "natural", or tiems 23a or 28a-f show od other than "natural", or tiems 23a to 28a-f show event. It e Medical Examiner must be multified at	by Fur	1 ☐ Never Married 2 ☐ Married  ***********************************	Armed Forces?  1 Yes YN  If Yes, Give  Year or Dates:	0	fYes, specify Cuba I□Yes <b>XX</b> No	n, Mexican, Puert Specify:	o Rican, etc.)		ack, White, e ify: <b>Whi</b>		
Maryland 21215-0036	72 hou natura iical E	eted	15. Decedent's Educ (Specify only highest grade	ation		lent's Usual Occupa		tina	16b. Kind of	Business/Ind	ustry	
12	within sne.	Completed	Elementary/Secondary (0-12)	College (1-4or 5-	+) life. L	kind of work done d OO NOT use retired,	)		-		_	
9	filed y Hygie other i	Be Co	17. Father's Name (First, Middle, Last)		Port	rait Phot	18. Mother's Nan			otogra	phy	
ylan	should be filed withir and Mental Hygiene.  I marked other than umatic event, If a M.	To B	James Omar Walsh				Blanche	Yattaw				
Mar	12 sho h and 7 is ma		19a. Informant's Name/Relationship (Typ		La co	g Address (Street a						
	s 1 and 2 should f Health and Men item 27 is marke other traumatic		James C. Moses / S 20a. Method of Disposition	on	20b. Place of Dispos	Cove Pt.		Tilgh	man Ma 20c. Location			1
altimore,	Pages nent ol ant: if i		1XX urial 2 □ Cremation 3 □ Re  '4 □ Donation 5 □ Other (Specify)	emoval from State	U.S.Naval	Acad.Cen		/2007	Annapo:	lis. M	arvlan	d
Balt	permit. Pages 1 an Department of Heal Important: If item 2 any injury or other once.		21. Signature of Funeral Service License	L	22	Name and Addres 7 Duke of	s of Facility $\hat{\mathbf{Jol}}$	ın M. Ta	ylor Fu	meral	Home,	Inc.
10	Physician /Medical Examiner		23a. Part1. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	e cause on each lin	э.	nengural	bry ar	rest		-,	Approximate Interval Betw Onset and D	eath
,0°	ficate be executed physician and ts the burial-transit	i Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		consequence of):	heart des	ear wi	th cing	while for	rlue	Jear	>
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C. Box	ath certi	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	ic. If yes, outcome of 1 Live birth 24 4 Pregnant at t	Fetal death 3	Ectopic pregnancy Other (specify)				ate of deliver	•	ear .
<u>s,</u>	w requires that the de been signed by the s should be detached	ρ	Part II Other significant conditions cont	ributing to death bu	t not resulting in the un	derlying cause give	n in Part I.		obacco use cor			
S S	w requi	eted	Coad Del Ask	a Andra	- COUR				Yes 2□No		bly 4 □Ur	
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<u>Iza</u>	iician: Th certificate rector, pag	BeC	25. Was case referred to medical examiner?	un ju	Jovens		26. Place of Dear		ne)		: LI 140	
ō	Phys this aldi	P.	1 ☐ Yes 2 ☐ No ☐ Ho	spital: 1 Inpatien		3 DOA Other	r: 4 Nursing Ho	ome 5 Resid	dence 6 🗆 Ot	ner (Specify)		
0	nding ath. r: Afte e fune	ation;	1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day	Year) Injury	28c. Injury Work' M 1 \( \text{Y}	es 2 No	zou. Describe :	low injury occu	rea		
DIVISION	il or Atta after des I Directo d in by th	ertific	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injur building, etc.	y - At home, farm, stre (Specify)	et, factory, office		28f. Location (S City or Tov		ber or Rural	Route Numbe	er,
	To the Hospital or Attanding Physician: whithin 24 hours after deals. To the Funeral Director: After this certific completely filled in by the funeral director,	edical C	29a. Certifier Certifying Physic (Check only one)	cian: To the best of er: On the basis of and manner state	examination and/or invi	occurred at the time estigation, in my opi	e, date and place, inion, death occur	and due to the red at the time,	cause(s) and m	anner as sta	ted. he cause(s)	
	within To the	Me	29b. Signature and title of certifier	100	A \	29c. License	number		29d. Date sign	ed (Month, D	ay, Year)	
	Spr		William H	wood )	MD		8715		9/1	9/07		
	٠٠٠.		30. Name and address of person who com William H. Wood, Jr		ath (Item 23a) (Type, F Kings Wood	*	aston Ma	haelvre	21601			
	Sta	te	31. Date filed (Month, Day, Year)	32. Redistrar	's Signature	A	-con Tic	** A TOIM	Z1001			

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month planter Day 25 2007 :30 Oscar David MCGOWAN 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Washington County Hospital Washington Hagerstown Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 1**X** M 2□ F Months 85 215-14-1177 May 7, 1922 Maryland Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b County 1 ☐ Yes 2√2 No Maryland Washington Hagerstown 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 12808 Oak Hill Avenue 21742 <u>USA</u> 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1∑Yes 2 No If Yes, Give Year or Dates: WW II 1 Never Married 2X Married 1 ☐ Yes 2 X No Specify Specify: 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 6 0 Carpenter Self 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) William McGowan Ida Marshall 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David McGowan - Son 130 Clearview Place, Carlisle, Pa. 17015 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cedar Lawn Mem. Park 9/28/07 Hagerstown, Maryland 21. Signature of Faneral Service Licenses 22. Name and Address of Facility Minnich Funeral Home W 415 E. Wilson Blvd. Hagerstown, Maryland 21740 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) neumonia Due to (or as a consequence of): DISCASE Coronary Sequentially list conditions Due to for as a conse vience of cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Disease 2 hronic Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? brikation 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 1□ Yes 2 **□**/Ño 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred

Physician /Medical Examiner

**Physician** 

Examiner

**Funeral** 

Director

ns 23a or 28a-f show must be notified at

r than "natural", or items.

filed within 72 hours after death with the

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permit. Pages 1 and 2 to Department of Health ar Important: If Item 27 is any injury or other trau

Baltimore, Maryland 21215-0036

Director

Funeral

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Completed

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/Medical

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Physician/Medical

The law requires that the death certificate be executed burial-trar physician the as 1 asn for ed by the a detached f signed t page 2 s certificate has Physician: funeral director, this After Hospital or Attending 24 hours after death.

E Funeral Director: A letely filled in by the fi death

Division or Vital Records, P.O. Box 68760,

Completed by Be Certification: To 27. Manner of Death

29a. Certifier

(Check only one)

Medical

completely

1 | Yes 2 | No 5 ☐ Pending investigation 1 Natural 2 Accident

3 Suicide 4 ☐ Homicide

6 ☐ Could not be

and manner stated.

32. Registrar's Signature

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 Yes 2 No

Injury

28f. Location (Street and Number or Rural Route Number, City or Town, State) 🕰 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier

29c. License number 0060396 29d. Date signed (Month, Day, Year) 26

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WILZHED

21740

3H-10+1 State Registrar

To the I within 24

State of Maryland / Department of Health and Mental Hygiene Karen M. Miller-Gottesman 1- For State Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day Year September 30, 2007 0315 hrs Medical Examiner Miller-Gottesman Karen Marie 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Calvert 3838 9th Street North Beach 9. Birthplace (State or 5. Social Security Number If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min. Director Feb. 10,1959 Country) 215-72-1692 2X F М 48 RI Usual Residence of Decedent 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits AUE 1 X Yes 2 No or 28a-f show Calvert North Beach MD permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a nr 28a-f ehn Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 3838 9th 20714 U.S.A. Street Funeral 11. Mantal Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? White, etc. 1 Never Married 2 Married 2 X No Yes If Yes, Give Yea Yes 2 X No specify: Specify: white 3 X Widowed Divorced ð 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 fiber optic co. business manager 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William Miller Joyce Fitzgerald 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2490 Lower Marlboro Rd., Owings, MD 20736 Thomas J. Raymond, brother 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 20a. Method of Disposition crematory or other place) Burial 2 X Cremation 3 Removal from State Metropolitan Crematory110-3-2007 Alexandria, VA Donation 5 Other Specify: 22. Name and Address of Facility 24\_Sonature of Funeral Service Liger Rausch Funeral Home, P.A. Mt. Lane. Owinas. Harmony ons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval lisease, or complica **Physician** failure. List only one cause on each li Between Onset and /Medical a. Intracerebral Hemorrhage Death Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of) b. Hypertensive Cardiovascular Disease Sequentially list conditions, Examiner if any, leading to immediate Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last executed and Physician/Medical tending physician a UNPENDED AMENDED The law requires that the death certificate be Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 3 Ectopic pregnancy Year Live birth Fetal death Month Day past 12 months' Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 V Unknown g Unknown signed by the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ş 1 Yes 2 No 3 Probably 4 V Unknown Completed 24b. Were autopsy findings available 24a Was an autopsy prior to completion of cause of this certificate has performed? death? ✓ Yes 2 No 1 🗸 Yes 2 No the Hospital or Attending Physician: 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Nursing Home 5 Residence 6 ✔ Other: Scene Inpatient 2 ER/Outpatient 3 DOA 1 🗸 Yes ဥ 28a. Date of Injury After 1 27. Manner of Death 28h. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 V Natural Yes 2 No Pending 24 hours after death. Director: 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be or Town, State) within 24 hours a To the Funeral I determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 📝 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. October 1, 2007 30. Name and address of person who completed cause of death (Item 23a) Carol Allan, MD Assistant Medigal Examiner 111 Penn Street, Baltimore, MD 21201 Year) 2. Registrar's Signature 2007 Registrar

DHMH 17 Rev 1/2001 **OCME 2006** 

			1 - For State Registrar	State of M		d / Depa	rtment of H tificate of L	ealth and	Mental Hyg	iene	007	32484
П	Physici		1. Decedent's Name (First, Middle Madelon M.						2. Date of Deat Month	Day	Year	3. Time of Death
	/Medic Examir		4a. Facility Name (If not institution,		·)		4b. City, Town, or	Location of Deat	Septen,	4c. C	23, 200 county of Death	
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	Funeral Director		5. Social Security Number 222-03-1925 Usual Residence of Decedent	6. Sex 7. A 1 □ M 25€14€	ge (In yrs. Ia		Months Days	If Under 24 Hrs Hours Min.			Col	place (State or Foreign untry) Vilm., DE
	aryland phow	_	10a. State 10b. County	1	10c. City	Town or Lo				, , , ,		10d. Inside City Limits
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Bal	permit. Pag Depertment Important: I any Injury o once.		21. Signature of Funeral Service L	4700	+	D 22	ANIELS 12 N. B	s of Facility & HUTCH road St	HISON FU	NER lidd	AL HO	ME LLC n, DE 1970
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	To the Hospital or Attent within 24 hours after deatt To the Funeral Director: completely filled in by the	Medical C	29a. Certifier (Check only one)  1 Certifying 2 Medical E	Physician: To the best xaminer: On the basis of and manner st	of examination	illadge, death on and/or invi	oncurred at the time astigation, in my op	e, date and place inion, death occu	i, and due to the ca irred at the time, da	uta(t) ar te and pl	nd namer at lace, and due	stated. to the cause(s)
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-			30. Name and address of person w		death (Item :	23a) (Type, F	Print)	3 N 21	12.5%.	1=	1k Ton	, 24, 2007
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DHMH 17 Rev 1/2001

State Registrar

			1 - For State Registrar		<b>f</b> arylar		artmen rtificate			ind M	ental Hygic	ene 3. N2 0	07	32486
	Physic /Medi		1. Decedent's Name (First, Middle, Mary Lucille C	last) Dliver							2. Date of Death Month Septembe		Year 2007	3. Time of Death 10:23 P. M
1	Exami		4a. Facility Name (If not institution, give street and number) Genesis LaPlata Center					4b. City, Town, or Location of Death LaP1ata				4c. County of Death Charles		
	Funeral Director		5. Social Security Number 6. 219-78-3660  Usual Residence of Decedent	Sex 7. A 1 ☐ M 2 ☑ F						Date of Birth (Month, Day, Year)  10 9. Birthplace (State or Foreign Country)  11 10 26,1933 Maryland				
	Maryland -f ehow	tor	10a. State 10b. County  MD Char1	es		y, Town or Lo						_	10	Od. Inside City Limits 1 XYes 2 No
	h with the	Funeral Director	10e. Street and Number One Magnolia Dr	ive			10f. Zip	Code 206	46		100	g. Citizen of V USA	What Count	
980	within 72 hours after deeth with the Maryland ene. then "neturel", or items 23a or 28e-f ehow ta Madigal Examinar maat ke notified at	þ	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☒ Widowed 4 ☐ Divorced	Armed Forces	1 Yes 217 No			Vas Decedent of Hispanic Origin? (Specify Yes or N Yes, specify Cuban, Mexican, Puerto Rican, etc.)  Yes 2 No Specify:			cify Yes or No- Rican, etc.)	lo- 14. Race - American Indian, Black, White, etc.  Specify: White		
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	es 1 and 2 sl of Health and I Item 27 ie r r other traur		19a. Informant's Name/Relationship Mary Edna Kellu: 20a. Method of Disposition	m/Daughter	20b. P		Box	334,	СоЪЪ	Is1a	nd,MD 20			
Baltimore,	permit. Pages Department of I Important: If It any Injury or o		Burial 2 Cremation 3 4 Donation 5 Other (Spec	rity)	' 1	rist C	hurch	Cem	. 1		2007 W	ayside PA	,Mary	land
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<b>=</b> ∄	Se se	일	examiner?  1 Yes 2 40	Hospital: 1 ☐ Inpatie		ER/Outpatient 28b. Time of		Other	4 Nurs	ing Home	Check only one  5 Residence d. Describe how i			
DIVISION	Attending ir death. ector: Afte by the fun-	Certification:	1 ★ Natural 5 Pending 2 Accident investigatio 3 Suicide 6 Could not be determined	e 28e. Place of Inj	ury - At hor	Injury	М		s 2 No	,	f. Location (Stree			Pouta Mumbar
בֿ		6	29a. Certifier 15 Certifying Pl	building, et	of my know	ledge death	occurred at	the time	, date and		City or Town, S	tate)		
1	within 2- To the F complete		one) 29b. Signature and title of certifier	and manner st	ated.	_ M		bicense r		occurred		and place, ar		
2	211		30. N mer and andress of person who	completed cause of d	eath (Item	23a) (Type, P	rioti	12	- 06	04	mis	9/2	2575	)7
4	Stat Registra	٧ .	31. Date filed (Month, Day, Year) SEP 2 6	32. Registra 2007	ar's Signatu	ure do		011		716/1	- 1000			

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Vivian Bailey Pilchard 24 20017 4a Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Lenter Pledical Alisbury Wicomics If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 6. Sex 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Months Days 1 M 2 X F 216-48-5843 64 7/17/1943 MD Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Worcester Snow Hill 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 201 W. Market St. 21863 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 21K No Specify. 3 ☐ Widowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Cosmetologist Hair Salon 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James Lora Bailev Flora Vincent 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Clarence W. Pilchard/husband 201 W. Market St., Snow Hill, MD 21863 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cape Henlopen Crem. 9/28/2007 Frankford, DE 21. Signature of Fun at Service Licensee 22. Name and Address of Facility Burbage Funeral Home 108 William St., Berlin, MD 21811 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ancientic Cancer Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underl, in Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4□Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Kenal 1 Yes 2 No 3 Probably 4 donknown 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 24a. Was an autopsy performed 2 100 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Impatient 2 ER/Outpatient 3 DOA 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 1 Natural 2 Accident

**Physician** /Medical Examiner Examiner certificate be execute

**Physician** 

/Medical

Examiner

Director

Funeral

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Completed

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**Funeral** 

Director

r than "natural", or Items 23a or 28a-f shov the Medical Examiner must be notified at

and Mental Hygi

permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra

injury or other traumatic

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Maryland

Baltimore,

Box 68760.

P.O.

Division or Vital Records,

-48-5843

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attending physician the ģ page 2 s certificate has this After

Physician/Medical ģ Completed Be <sup>2</sup> Certification: the Funeral Director: After according to the funeral Director of the funeral filled in by the funeral

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the

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Hospital or Attending

State Registrar

Medical

29a. Certifier (Check only one)

29b. Signature and tit

25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death

5 ☐ Pending investigation 3 ☐ Suicide 4 Homicide

6 Could not be determined

Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 Yes 2 No

29c. License number HO06453

Salisbury M.

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Michael 31. Date filed (Month, Day, Year) 2 6 2007 Carroll

2 7

		,	For State Registrar	State of Ma	aryland / Depa <i>Cei</i>	artment of F rtificate of		ental Hyوا ا	giene Reg. N 20	07	32488	
į,	Physici		1. Decedent's Name (First, Middle,	Last)				2. Date of Dea	ath Day	Year	3. Time of Death	
na fine	Physici: /Medic		Merrilee J. I	ossner					ber 21.		3:29 P M	
	Examin	er	4a. Facility Name (If not institution,	give street and number)		4b. City, Town, o	r Location of Death		4c. Count	y of Death		
-	<u> </u>	70	5332 Westpath 5. Social Security Number		(In yrs. last birthday)	Bethesda	a If Under 24 Hrs.	9 Date of Pirt	Mont	gomer		
5 . k:	Funeral Director		072-34-5668 Usual Residence of Decedent	1 M 2 N F	64 Yrs.	Months Days	Hours Min.	8. Date of Birt (Month, Da Jan 15	, Year) 1943	New New	lace (State or Foreign try) York	
	land ow		10a. State 10b. County		10c. City, Town or Lo	cation				1	0d. Inside City Limits	
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	n the	irec	10e. Street and Number	,		10f. Zip Code			10g. Citizen of	What Coun	itry?	
	th wit 23a o Ist be	alD	401 State Street	: #M302		03801		Ţ	USA			
36	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or Items 23a or 28a-f show aumatic event, the Medical Examiner must be notified at	by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Marrie  3 □ Widowed 4 【XDivorced	12. Was Decedent E Armed Forces?  1  Yes 2  If Yes, Give Year or Dates:	lo l	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 No	lispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)	- 14. Ra Bla Speci	ce - Americ ick, White, fy: Whi	etc.	
21215-0036	2 hou atura cal E		15. Decedent's	s Education	16a. Dece	dent's Usual Occup	pation		16b. Kind of E			
215	hin 7; an "n Medi	Completed	(Specify only highest Elementary/Secondary (0-12)	grade completed)	(Give	kind of work done OO NOT use retired	during most of work d)	ing			•	
2	filed within Hygiene. rther than " ent, the Mec	Son		College (1-4or 5- 5+	Folk	Art Speci	ialist		Art/An	tique	s	
Maryland	be file tal Hy d oth	Be (	17. Father's Name (First, Middle, L	ast)			18. Mother's Name		Maiden Surna	me)		
yla	should be I and Mental I s marked of umatic eve	٦°	Sidney Possner				Julia La					
Jar	12 sh n and r Is m raum		19a. Informant's Name/Relationshi			,	and Number or Rui			, State, Zip	Code)	
e,	1 and Healtl		Karen B. Possner 20a. Method of Disposition	/Sister	5332   20b. Place of Dispo		Way Beth	esda, MI	20c. Location	- City or To	uun Stato	
פֿר	permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 Is marked any Injury or other traumatic es once.		1 Burial 2 Tremation		cemetery, cree Chesapeak	natory or other plac	ce)		Beltsvi	,		
altimore,		ì	4 □ Donation 5 □ Other (Sp. 21. Signature of Funeral Seffyice L									
8 —	Dep Impo		Devely f	Hestille	MO1251 B	everly L.	ss of Facility e Crematio . Heckrot	te, P.A.	. Clark		e, MD 21029	
			23a. Part1. Enter the disease, or o shock, or heart failure. List o	omplications that caused nly one cause on each lin							Approximate Interval Between Onset and Death	
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	/Medical Examiner		rooming in dodair,	Due to (or as a	a consequence of):							
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58760,	icate be executed physician and s the burlal-transit	edical		d								
_	ertifice ing ph	Med	IF FEMALE:									
Вох	death certifi attending	Physician/M	23b. Was decedent pregnant	23c. If yes, outcome   1 Live birth	2 ☐ Fetal death 3 ☐	Ectopic pregnancy	/			ate of delive	ery Day Year	
P.O.	the a	ysic	in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	4□Pregnant at 9□Unknown	time of death 5	Other (specify) _				01141	Day Tour	
	The law requires that the death certif tte has been signed by the attending age 2 should be detached for use as	Ph	Part II. Other significant condition	s contributing to death bu	it not resulting in the u	nderlying cause giv	en in Part I.	23e. Did to	obacco use con	tribute to th	ne cause of death?	
Vital Records,	uires s sign ld be	d by						1 🗆 \	res 2 No	3 ☐ Prob	ably 4 Unknown	
် ဝ	w req	Completed						24a. Was	an 24h	Were auto	psy findings available	
æ	sician: The law certificate has l irector, page 2 s	dmo						autop	rmed2	prior to cor death?	mpletion of cause of	
ta		Be C	25. Was case referred to medical				26. Place of Deat		2DNo	1 □ Yes	2 No	
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0	ding Ph .r After th funeral		27. Manuer of Death 1 Natural 5 Pending	28a. Date of Injur (Month, Day	y 28b. Time of Injury	28c. Injur Wor		28d. Describe h			The factor of the same	
<u> </u>	endir eath. or; At	atio	2 ☐ Accident investiga	ition			Yes 2 □ No					
Division or	al or Attendi s after death. Il Director: A d in by the fu	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	ed 28e. Place of inju	ry - At home, farm, str (Specify)	eet, factory, office		28f. Location (S City or Ton	Street and Num vn, State)	ber or Rura	l Route Number,	
	urs af											
	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific: completely filled in by the funeral director,	Medical	29a. Certifier  (Check only one)  1 ✓ Certifying  2 ☐ Medical E	Physician: To the best of xaminer: On the basis of and manner sta	examination and/or in	n occurred at the till vestigation, in my o	me, date and place, opinion, death occur	and due to the red at the time,	cause(s) and m date and place	anner as st , and due to	tated. the cause(s)	
	To th within To the	Me	29b. Signature and title of certifier			29c. Licens	e number		29d. Date signe	ed (Month,	Day, Year)	
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(	The		30. Name and address of person w	ho completed cause of de	40 FRAN	KUIN SL	QUARE DI	R. BA	LTIMAR	E M	0.21236	
10	Sta		31. Date filed (Month, Day, Year)	32. Registra	ur's Signature	,			, , , , , , ,			
	Registr	ar	SEP 2 6	ZUU/ Diney	w Dr De	and I						

			For State Registrar	State	of Mar	yland / Dep	artment of F			, 0		00100
		el(	Registrar  1. Decedent's Name (First, Midd	le (ast)		Ce	runcale or	Deain		Reg Date of Death	3. No.2007	3 2 4 8 9 3. Time of Death
14.	Physici		Tasioula G.	Piknis					1	√lonth	Day Year	
	/Medio Examir		4a. Facility Name (If not institution		umber)		4b. City, Town, o	or Location of		ptembe	20, 200 4c. County of Dea	
	LAGIIII	ici	Fairland Adve	-		& Rehab.	Silver					omerv
	Funeral		5. Social Security Number	6. Sex		In yrs. last birthday,	If Under 1 Year	If Under	24 Hrs.   8. D	ate of Birth	9 Bir	thplace (State or Foreign
	Director		218-82-8558	1 ☐ M 2 <b>K</b> F	6:	Yrs.	Months Days	Hours		Month, Day, Y	1946	ountry) Greece
	D >		Usual Residence of Decedent		1.	0c. City, Town or Lo	antina .					
	shov shov	5	10a. State 10b. County	1	'	oc. Ony, Town or Li	cation					10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	the N 28a-f otifie	Director	Maryland   10e. Street and Number	Montgome	ry	Silv	er Spring	<b>1</b>				1
	a or		12029 Swallo	w Falls (	Court		10f. Zip Code 20904			100	g. Citizen of What Co USA	ountry?
	leath ns 23 musi	eral	11. Marital Status	12. Was De		erin II.S 13		dispanic Ori	igin? (Specify	Ves or No-	14. Race - Ame	arican Indian
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by Funeral	1 □ Never Married 2 □ Mar 3 ☑ Widowed 4 □ Divorced	ried Armed F	forces? 2 <b>3</b> No live		Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 ☐ No	an, Mexicar		n, etc.)	Black, Whi Specify.Whi	te, etc.
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Nar	12 sho h and risma rauma		19a. Informant's Name/Relations Akis G. Pikni								City or Town, State,	Zip Code) , MD 20904
	is 1 and 2 of Health a item 27 is other trae		20a. Method of Disposition						Date			
altimore,	Pages nent of I ant: If ite ary or o		1 K Burial 2 ☐ Cremation		n State	20b. Place of Dispo cemetery, cre Gate of			ept.	24,	c. Location - City or	
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Ba	permi Depar impol any Ir			c 020							Home Inc.	
ļ.	DE L		23a. Part1. Enter the disease, o	r complications that	caused the	e death. Do not en	er the mode of dyir	ng, such as	cardiac or res	piratory arrest	ver Sprin	g, MD 20901 Approximate
	Physician <b>S</b>		shock, or heart failure. Lis Immediate Cause (Final	•		c Breast	<b>C</b>					Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	a.		onsequence of):	Cancer					
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. Box	The law requires that the death certifs to has been signed by the attending lage 2 should be detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 🕱 No		birth 2 [ nant at tim	Fetal death 3	Ectopic pregnancy Other (specify)	у			23d. Date of de Month	livery Day Year
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	igned be de	by	Part II. Other significant conditi	ons contributing to	death but n	ot resulting in the u	nderlying cause giv	en in Part I.	. 2			the cause of death?
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E		9							1	performé ∐Yes 2 <b>∑</b>	d?   death?	2 □ No
Žį.	Physician: The this certificate ral director, pag	Be	25. Was case referred to medica examiner?	Hospital:			Tau		of Death (Che	eck only one)		
0	1 di ii	P	1 Yes 2 No 27. Manner of Death	28a. Date	Inpatient	2 ER/Outpatier		4 LZ-Nui			ce 6 □Other (Spe	cify)
Division or	ding I. After fune	ioi	1 Natural 5 ☐ Pendir	ng (Mo	nth, Day Ye	ear) 28b. Time o	Wor	yat k? Yes 2⊡1		Describe how	injury occurred	
S	# 0 0 ×	icat	3 Suicide 6 □ Could	not be	e of injury	- At home, farm, str		res Z	-	ocation (Stro	et and Number or Ri	unal Pauta Alumbas
<u>≥</u>	a # # # =	Certification:	4 ☐ Homicide determ	nined build	ling, etc. (	Specify)	oot, taotory, omoo		201. C	City or Town, S	State)	Trai noute Number,
	spita nours neral / fillec	- 1	29a. Certifier TC Certifyin	ng Physician: To th	e best of m	ny knowledge, deat	n occurred at the tir	ne, date an	d place, and d	ue to the caus	se(s) and manner as	s stated.
	To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b	Medical	(Check only 2 ☐ Medical one)	Examiner: On the	basis of ex nner stated	amination and/or in	vestigation, in my o	pinion, dea	th occurred at	the time, date	e and place, and due	e to the cause(s)
	To the Hospital within 24 hours a To the Funeral C completely filled i	ž	29b. Signature and title of certifie	n n		1 .	29c. Licens			29d	. Date signed (Mont	h, Day, Year)
	7-		1. Van 9	K Ko	ad	dul	D52	261		Se	ptember 2	21, 2007
		Ī	30. Name and address of person	. /	1		,					
			Alan R. Segal,			go Circle		Sprir	ng, MD	20902		
	Sta Registr		SEP 2 4	2007	negistrars Www	Signature	with the					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2007 For State State AMEND#23a(a-d)per FH9/24/07, BMW, McGertificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day Year aurence Charles 7:28PM 2007 xptember /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** uth mure If Under 24 Hrs. 8 Med Manyland Baltimore If Under 1 Year 5. Social Security Numbe 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Min. Months Days Hours 1XM 2□F Director 218-38-9341 65 July 22, 1942 Pennsylvania Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any linjury or other traumatic event, the Medical Examiner must be notified as once. 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits Directo 1 ☐ Yes 2 ☑ No Maryland Howard Clarksville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12913 Kentbury Drive Funeral 21029 United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specity Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: þ 3 Widowed 4 Divorced Caucasian Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Automotive Technician / Mechanic Automotive 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Raymond Catherine Abigail Pfister Harris 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy Pfister / Spouse 12913 Kentbury Dr; Clarksville, Maryland 21029 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) Ft. Lincoln Crematory 9/13/2007 Brentwood, Maryland 22. Name and Address of Facility
Simple Tribute Funeral and Cremation Center 21. Signature of Funeral Service Dicensee <u>1040 Rockville Pike, Rockville, Maryland 20852</u> 23a. Part. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immedi e `ause (Final disease or condition resulting in death) **Physician** JUNS15 /Medical (or as a consequence of):

j System Organ Failure **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine To the Hospital or Attending Physicial. The law requires that the death certificate be executed Ischemic colon 24 hours physician and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. Physician/Medical <u>Ischemic small bowel</u> 24 hours IF FEMALE: 23c. If yes, outcome pf pregnancy 1 □Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death Day Year 5 Other (specify) sate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy perforn certificate 1☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of eath 28a. Date of Injury After t 28h. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Natural
2 Accident (Month, Day 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No Director: , 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined hours after within 24 hours at To the Funeral D completely filled i 1 \*\*Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 \*\*Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29c. License number 29b. Signature and title of certifier P21050 September 9, 2007 leted cause of death (Item 23a) (Type, Print) (Month, Day, Yea, South

State Registrar

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygie 200 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** September 18, 2007 A. Ringrose-Stona /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Prince George's 10305 Keepsake Lane Upper Marlboro If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dav. Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1∭M 2□F Yrs. Director Dec. 16, 1969 579**-**13-3406 Jamaica Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 17 is marked other than "naturel", or iteme 23a or 28a-f show traumatic event, the Mudical Examinar must be notified at 1 € Yes 2 No Maryland Prince George's Upper Marlboro Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10305 Keepsake Lane 20772 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. e filed within 72 hours after if Hygiene. other than "naturel", or ite 1 Never Married 2 Married Specify: Black 1 ☐ Yes 2 ➡ No Specify: δ 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 4 Software Engineer Private years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) . Pages 1 and 2 should be fill thent of Health and Mental H tant: If item 27 is marked other. Daphne Lowe Rudolph Oliver Stona 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Robert O. Stona - Brother 15709 Atlantis Drive Bowie, MD 20716 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Department of important: If eny injury or one. Lee's Crematory Sept. 25, 2007 Clinton, MD 21. Signature of Funeral Service Lices 22. Name and Address of Facility Stewart Funeral Home, Inc. 4001 Benning Road, NE Washington, DC 20019 23a. Part Nenter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, scheart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Immunale ficiency Vinus **Physician** disease or condition resulting in death) Human /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): signed by the attending physician and be detached for use as the burial-transit that initiated events resulting in death) Last certificate be exec Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 2 Fetal death 3 Ectopic pregnancy Month 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 ☐ Probably 4 ☐Unknown

þ

Completed

Be

Certification:

completely filled in by the

Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifies

29b. Signature and title of certifier

29a. Certifier (Check only one)

25. Was case referred to medical

1 Yes 2 No

27. Manner of Death

1 Natural

2 Accident

4 Homicide

3 ☐ Suicide

Conform oake MD

5 | Pending

investigation

6 Could not be determined

D16619

28c. Injury at Work?

29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

1 Yes 2 No

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

28f. Location (Street and Number or Rural Route Number, City or Town, State)

24a. Was an autopsy performed

2 🗹 No

28d. Describe how injury occurred

DR. BALTIMORE

1 Yes

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

C.VERGARA-SOARES FRANKLIN SQUARE 9940 32. Registrar's Signature

SEP 2 5 2007

State Registrar Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

28a. Date of Injury (Month, Day Year)

			1- State of Maryland / Dep Registrar Ce	artment of Health and N rtificate of Death		ene g. No. 2007 32492					
	Physici /Medi		Decedent's Name (First, Middle, Last)  JESSIE L. REEVES		2. Date of Death Month						
	Examir		4a. Facility Name (If not institution, give street and number) SOUTHERN MARYLAND HOSPITAL	4b. City, Town, or Location of Death CLINTON, MD		4c. County of Death PRINCE GEORGES					
~	Funeral Director		5. Social Security Number 243-38-5881  Usual Residence of Decedent	If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, 1						
	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	Funeral Director	10a. State         10b. County         10c. City, Town or Lead           MD         PRINCE GEORGES         UPPER MAR           10e. Street and Number         11413 CAPSTAN DRIVE           11. Marital Status         12. Was Decedent Ever in U.S.         13.		U	10d. Inside City Limits  1					
nd 21215-0036	n 72 hours after ( "natural", or iter e ilcal Exa <u>miner</u>	Completed by Fur	1 □ Never Married 2 □ Married 1 □ Yes 2 □ No If Yes, Give Year or Dates:  15. Decedent's Education (Specify only highest grade completed)  16. Decedent's Education (Give (Give Internal Intern	If Yes, specify Cuban, Mexican, Puerto    The standard of Specify:	10	Black, White, etc.  Specify: BLACK  16b. Kind of Business/Industry					
	be filed withi Ital Hygiene. d other than event, the M	Be	1 College (1-4or 5+)   1 YEAR   SCHOOL TEACHER   PRIVATE								
Maryland	1 and 2 should be Health and Mental em 27 is marked o ither traumatic eve	2	CHARLES HARRIS  MARY ELLA MARSHMAN  19a. Informant's Name/Relationship (Type. Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  JAMES A. REEVES/SON  11413 CAPSTAN DR. UPPER MARLBORO, MD 20772								
Baltimore, I	permit. Pages 1 and Department of Health Important: if item 27 any injury or other tt		20a. Method of Disposition  1 \( \mathbb{Z}\) Burial 2 \( \mathbb{C}\) Cremation 3 \( \mathbb{R}\) Removal from State 4 \( \mathbb{D}\) Donation 5 \( \mathbb{O}\) Other (Specify)   21. Signature of Funeral Service Licensee 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MD 20785								
The second second	Physician /Medical Examiner  the burial-transit	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):									
ls, P.O. Box 68760,	es that the death certifi igned by the attending I be detached for use as	by Physician/Medical		□Ectopic pregnancy □ Other (specify) Inderlying cause given in Part I.		23d. Date of delivery  Month Day Year  acco use contribute to the cause of death?					
Vital Records,		e Completed	25. Was case referred to medical	00 8000 4000		24b. Were autopsy findings available prior to completion of cause of death?  No 1 □ Yes 2 □ No					
Division or Vit	or Attending Physiter death. Director: After this in by the funeral dir	25. Was case referred to medical examiner?  1									
	To the Hospital or At within 24 hours after d To the Funeral Direct completely filled in by	edical	29a. Certifier (Check only one)  1 ertifying Physician: To the best of my knowledge, deat 2 Medical Examiner: On the basis of examination and/or in and manner stated.	ivestigation, in my opinion, death occur	and due to the cau	use(s) and manner as stated, te and place, and due to the cause(s)					
	Vith Vith To To To To To To To To To To To To To	Σ	29b. Signatury and trie of dertifier  OPESANO  30. Name and ad rest of person who completed cause of death (Item 23a) (Type,		6 C	d. Date signed (Month, Day, Year)					
	Sta Registr		31. Date filed (Month, Day, Year) SEP 2. 5 2007  SEP 2. 5 2007  SEP 2. 5 2007	Clinton ini	207	35					

			For State Registrar		State of M	arylan		artment of H		and Mer		ene 200	7	32493
	Physici		1. Decedent's Name (F	PION		EN	BER	26			Date of Death Month	Day 21, 2	ar 2007	3. Time of Death 4 5 45 PM
	/Medic Examin		4a. Facility Name (If no	institution, give		<del>-</del>		4b. City, Town, or	Location of			4c. County of [		
	Zxamii		Hebrew Ho	ome of G	reater Wa	shing	gton	Rockvi1	.1e			Montgon	nery	
	Funeral Director		5. Social Security Numb 114-09-2430	oer 6. Se			last birthday) Yrs.	If Under 1 Year Months Days	If Under 2 Hours	24 Hrs. 8. Min. Ma1	Date of Birth (Month, Day, ) rch 17,	(ea()) 1918 N	Birthpla Counti	ace (State or Foreign ry)
	pu *		Usual Residence of De 10a, State 10	b. County		10c City	y, Town or Lo	scation					10	d. Inside City Limits
	short staryla	5		,	***		kville	oution.					,,,	1. Yes 2 No
	28a-1	ect	MD N	lontgome	L y	Koci	KVIIIE	10f. Zip Code			100	g. Citizen of Wha	t Count	v?
	with Sa or	Funeral Director	6121 Mont		ad			20852			US			,
	me 2:	era	11. Marital Status	lose Ro	12. Was Decedent	Ever in U.	S. 13.	Was Decedent of H	ispanic Orig	gin? (Specify	Yes or No-	14. Race - /		
36	rs after (	oy Fur	1 ☐ Never Married  3 ☑ Widowed 4 ☐	_	Armed Forces? 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:			If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	n, Mexican. Specify:	i, Puerto Rica	an, etc.)	Black, V Specify:	vhite, e Whi	
Ö	2 hou	Completed by	15	Decedent's Edi	ıcation		16a. Dece	dent's Usual Occupa	ation		16	5b. Kind of Busin	ess/Ind	ustry
215	hin 72	pie	(Specify of Elementary/Seconda	only highest grad	College (1-4or	5+)	(Give	kind of work done o DO NOT use retired	during most I)	t of working				
21	giene giene	E O	12	1,7 (0 1.2)	Conage (1 40)	.,	Home	maker				Own I	lome	
g	al Hy d oth	Be	17. Father's Name (First									aiden Sumame)		
yla	Ment Ment arked arked	2	Adolph Ro							el Cu				
Baltimore, Maryland 21215-0036	nd 2 shouth and 27 is m		19a. Informant's Name Norman Ros				1	ng Address <i>(Street a</i> 19th Stre				city or Town, Sta n, DC 20		
ē,	s 1 av f Hea item otha		20a. Method of Disposi	tion		20b. P	lace of Dispo	sition (Name of natory or other plac	(a)	Date	20	c. Location - City	or Tow	vn, State
Ë	Page lent o nt: if ry or		1 ∰Burial 2 □ C 4 □ Donation 5 □		Removal from State		. Araı	cat Cemet	ery 0	9/24/2	2007	Babylon,		
Balti	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural; or iteme 23a or 28a-f show important: if item 27 is marked other than "natural; or iteme 23a or 28a-f show any hjury or other traumatic event, it a Medical Examinar must be notified at once.		21. Signature of Funer	al Service Licens	eg/		22 C	Name and Address hapels, I	ss of Facility	y Danza 1170 l	ansky-G Rockvil	oldberg le Pike	Mem	orial
			23a. Part1. Enter the c	lisease, or comp	lications that cause	d the death								Approximate Interval Between
	Physician		Immediate Cause (Fin-		ne cause on each li	F.P.	127	HYPER	DTEN	1/9/1	21/			Onset and Death
	/Medical		disease or condition resulting in death)	-	a. Due to (or as	a consequ	uence of):	711101	-101		//		+	·
	Examiner		and the same of the same		CHRO	NIC	RE1	VAL F	FALL	UR	E			
	B #	ner	Sequentially list condit if any, leading to imme cause. Enter Underlying	diate	Due to (or as	a consequ					-			
	nd ransi	Examiner	cause. Enter Underlyin Cause (Disease or inju- that initiated events		c					-				
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ğ X	ertifica ding pt	Med	IF FEMALE:		330 If you guitooma	of organ								
Box 6	es that the death certific igned by the ettending p be detached for use as	Physician/M	23b. Was decedent pre in the past 12 mg	gnant	23c. If yes, outcome 1☐Live birth	2 Fetal	death 3	Ectopic pregnancy				23d. Date of Month		y Day Year
о. О	the de	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	0	4□Pregnant a 9□Unknown	t time of de	eath 5	Other (specify)						
	that t ed by deta		Part II. Other significal	nt conditions co	ntributing to death t	out not resi	ulting in the u	nderlying cause give	en in Part I.		23e. Did toba	cco use contribu	te to the	cause of death?
Records,	uires I sign IId be	d by	VASCU	LUAR	DEM	EN	TIK	)			1 🗌 Yes	200 3E	] Proba	bly 4 🗆 Unknown
Ö	w requir been si should	Completed									24a. Was an	24b. Wer	e autop	sy findings available
Be	he lav e has age 2	ᇤ									autopsy	prior deat	to com	pletion of cause of
ta	an: T tificet tor, pa	0	25. Was case referred	to medical					26 Place	of Death #C	1 □ Yes 2 l heck only one	ØNo 1□	res a	212 No
$\geq$	yeich is cer direct	To B	examiner?		Hospital:	ent 2	ER/Outpatier	nt 3 DOA Oth	or A			ce 6 □Other (	Specify)	
<u>0</u>	ng Ph ter th		27. Manner of Death	Pending	28a. Date of Inju (Month, Da	ıry ıv Year)	28b. Time o	f 28c. Injun Worl				injury occurred		
<u>ত</u>	ttendir death. stor: Af	atic	2 Accident	investigation					Yes 2 □ N	No				
Division of Vital	i or Att after de Direct	Certification:	3 ☐ Suicide 6 4 ☐ Homicide	Could not be determined	28e. Place of In building, e	jury - At ho tc. <i>(Specif</i> )	ome, farm, str y)	eet, factory, office		28f.	Location (Stre City or Town,	et and Number o State)	r Aural	Route Number,
_	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the eltending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit		29a. Certifier 1	Certifying Phy	sician: To the best iner: On the basis of	of my kno	wledge, deat	h occurred at the tin	ne, date and	d place, and	due to the cau	ise(s) and manne	er as sta	ited.
	the hain 24 the F	Aedical	one)		and manner st	ated.								
١	To To	Σ	29b. Signature and title	or certifier	4/	Via.	, 1	29c. Licenso	3 5 4	12/	290 62	d. Date signed (A	rontn, E BD	22 2007
ŀ	3		· por	unen	e cer	uur	uj'	1 1	///	10	10	110101	K	
			30 Name and address	of person who c	ompleted cause of	A) C	23a) Type,	10NTRO	IE RI	P, ROL	CKVIL	IE, MI	Z	22, 2007 0852
	Sta Registr	–	31. Date filed (Month, I	2 5 2007	2. Regist	rar's Signa	ture	et :						

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Eleonor Roman 1:30 a<sup>M</sup> 24, 2007 September 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Shady Grove Adventist Hospital Rockville Montgomery If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Hours 1 □ M 2 k F Yrs. 92 070-38-2979 March 25, 1915 Austria-Hungary Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No Maryland Montgomery Chevy Chase 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 2715 Blaine Drive 20815 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No Specify: 3 X Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Corsetiere Self Employed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Heinrich Reichsfeld Janka Fleischhacker 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) George H. Roman - Son 2715 Blaine Drive, Chevy Chase, Maryland 20815 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 2-☐Cremation 3 ☐Removal from State 1 X Burial 4 □ Donaxion 5 Other (Specify) King David Memorial Garden's 9/25/2007 Falls Church, Virginia 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 21. Signature of Puneral Service io-11800 New Hampshire Avenue, Silver Spring, Maryland 20904 se, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, a List only one cause on each line. 23a. Part 1. Enter the sees shock, or heart silure Approximate Interval Between Onset and Death Immediate Cause (Fin disease or condition 7 days INFARCTION MYOCARDIAL ACUTE resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery in the past 12 months? 1 ☐ Yes 2 ☑ No 1☐Live birth 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 1 🗌 Yes 3 ☐ Probably 4 ☐ Unknown 24a. Was an

**Physician** /Medical Examiner

permit. Pages 1 Department of H Important: If Ite any Injury or ot

**Physician** 

/Medical

Examiner

**Funeral** 

Director

than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at

Pages 1 and 2 should be filed within 72 hours after death with trent of Health and Mental Hygiene.
ant: If Item 27 is marked other than "natural", or items 23a or items or or other traumatic event, the Medical Examiner must be in

Baltimore, Maryland 21215-0036

Directo

by Funeral

Completed

Be ၉

the Maryland

Examine attending physician and by Physician/Medical Completed this certificate Be P Certification: After 

the Hospital or Attending Physician: The law requires that the death certificate be executed

5

Division or Vital Records, P.O. Box 68760,

IF FEMALE: 23b. Was decedent pregnant

5 ☐ Pending investigation

6 ☐ Could not be

determined

24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☑ No autopsy perform

26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury 28d. Describe how injury occurred

28b. Time of 28c. Injury at Work? (Month, Day Year) 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

CONTER DR. ROCKVILLE, MD

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

25. Was case referred to medical examiner?

1 Yes 2 No

27. Manner of Death

1 Natural

2 ☐ Accident

3 ☐ Suicide

29a. Certifier

Medical

State

Registrar

4 Homicide

(Check only one)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

29d. Date signed (Month, Day, Year)

30. Name and a s of person who completed cause of death (Item 23a) (Type, Print) MBDICAL

QIUFANG CHENG 31. Date filed (Month, Day, Year) SEP 25 2007

M.D. 9901 32 Registrar's Signature

4			1- State of Maryland / Department of Health and Certificate of Death	Mental Hygie	ne No. 2 0 0 7	32495						
		9	Decedent's Name (First, Middle, Last)	2. Date of Death		3. Time of Death						
	Physici /Media		Jerome Rodin	September	21, 2007	7:05 a M						
	Examir		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Dea	ath	4c. County of Deat							
		30.	Casey House Rockville  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hr	s. 8. Date of Birth	Montgom	ery hplace (State or Foreign						
ш	Funeral Director		085-18-2455		ear) Co	untry)						
			Usual Residence of Decedent	рссемьет	J, 1744 .							
	arylan show	_	10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits  12€ Yes 2 □ No						
	he Ma 18a-f	Director	Md. Montgomery Silver Spring	10-	. Citizen of What Co							
	with t	Dir	10e. Street and Number 10f. Zip Code 20906			untry :						
	Jeath Teath Teath Teath	Funeral	15100 Interlachen Dr. #114  11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Pue		US 14. Race - Ame							
36	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	þ	If Yes, Give 1 ☐ Yes 2½ No Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Dates: LILIT T	erto Hican, etc.)	Black, White Specify:	e, etc. White						
21215-0036	72 hou natura lical E	Completed	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of w	orking 16	b. Kind of Business/	Industry						
21	within 7	nple	(Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  Facilities Manager	I	Circuit							
	filed w Hygier ther th			ame (First, Middle, Ma								
anc	ould be fi Mental F arked ot atic evel	Be C	Leonard Rodin Tessie		don damamo,							
Maryland	i 2 should be filed v n and Mental Hygie is marked other t raumatic event, <u>th</u>	ပ	19a. Informant's Name/Relationship (Type. Print)  19b. Mailing Address (Street and Number or I	Rural Route Number, C	ity or Town, State, 2	Zip Code)						
	1 and 2 Health a tem 27 is		Evelyn Rodin/ Wife 15100 Interlachen Dr	. #114 Sil	ver Sprin	g, Md. 20906						
nore,			20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State  4 ☐ Donation 5 ☐ Other (Specific)  Judean Memorial Gardens		c. Location - City or Lney, Md.	Town, State						
Baltimore,	permit. Pages 1 a Department of Hes Important: If Item any injury or othe		4 Donation 5 Other (Specify)  21. Signature of Funeral Service Licensee  22. Name and Address of Facility Edward Sagel Fune 1091 Rockville Pil	1	<b>3</b>							
	40 = 60					Approximate						
	Dharistan		23a. Fart1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Interval Between Onset and Death disease or condition  Respiratory Failure									
1	Physician /Medical		disease or condition resulting in death)  a.   Respiratory Fallure  Due to (or as a consequence of):									
	Examiner		End Stage COPD									
	p ±	ner	Sequentially list conditions, if any, leading to immediate cause. E.iter Underlying Cause (Disease or injury that initiated events  b. Due to (or as a consequence of):  c.									
5	ecute and -trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last  C									
68760,	icate be executed physician and s the burial-transit	al E	bue to (of as a consequence or).									
687	ficate g phys is the	edical	d									
O. Box	The law requires that the death certificate has been signed by the attending I age? Should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify) □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □		23d. Date of del Month	ivery Day Year						
, P.O	that ined by detail			23e. Did tobac	co use contribute to	the cause of death?						
rds	w requires been signe should be	d by		1 ☐ Yes	2 No 3 Pr	obably 4x Unknown						
or Vital Records,	The law recate has bee page 2 shor	Completed		24a. Was an autopsy performe	d? prior to death?	ntopsy findings available completion of cause of						
tal		Φ	25. Was case referred to medical 26. Place of Dr.	1  Yes 2  eath (Check only one)	]No 1∐Yes	2□ No						
<u> </u>	lis dir	To B	examiner?  1   Yes   2x  No	Home 5 ☐ Residence	e 6 🔀 Other (Spe	cify)Hospice						
	fter		27. Manner of Death 1 □ Natural 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work?	28d. Describe how	injury occurred							
Division	Attending is death. ector: After by the funer	Certification:	2 Accident investigation M 1 Yes 2 No 3 Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office	28f. Location (Stree	et and Number or Ru	ıral Route Number,						
Ö	ital or /		#_nonlicide building, etc. ( <i>Specify</i> )	City or Town, 8								
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edical	29a. Certifier (Check only one)  1  Certifying Physician: To the best of my knowledge, death occurred at the time, date and plated the control of the contro	curred at the time, date	e and place, and due	e to the cause(s)						
	V Vith	N	29b. Signature and title of certifier  D0064615  29c. License number D0064615	9/	Date signed (Mont 21/07	h, Day, Year)						
	10		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Genevieve Wroblewski 6001 Muncaster Mill Rd. Roc	ckville, Md	. 20855							
	Sta Registi		31. Date filed (Month, Day, Year) SEP 2 5 2007 Segistrar's Signature									
	riogisti		1-00-									

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 9/20/2007 Hilda Ellen Reinacher 11:26 A<sup>M</sup> /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Chester River Hospital Center Chestertown Kent 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 10/28/1951 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Hours 1 □ M 2 🛣 F 222-52-6896 55 Director DE Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 X No Director MD Kent Rock Hall 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? hours after death with 5630 Circle Park Dr. 21661 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify. Specify: White 2 3 ☐ Widowed 4 ☐ Divorced Completed other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry illed within 72 h Hygiene. (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filled w
Department of Health and Mental Hygien
Important: If Item 27 is marked other th,
any Injury or other traumation. Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be David James Morris Ruth Catherine Cahall ٥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5630 Circle Park Dr. Rock Hall, MD 21661 Ray Reinacher/Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Chesapeake Cremation | 9/25/2007 Stevensville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Fellows, Helfenbein & Newnam 21. Signature of Funeral Service Licensee 130 Speer Rd. Chestertown, MD 21620 e 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Sty **Physician** ~ 9 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner tobacco Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine certificate be executed burial-transi that initiated events resulting in death) Last and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical the as IF FEMALE asn 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) the detached 9 Unknown 9 Unknown signed by i Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has autopsy certificate 1□ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 2 R/Outpatient 1 TYes 1 Inpatient 3□ DOA 70 28a. Date of Injury (Month, Day Year) filled in by the funeral 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 retifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number Mar 1 lun è 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 1+0056426 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 25/ 5. Boke min Kptz aulm. DO 1-ACA 31. Date filed (Month, Day, Year) 32. Registrar's Signature State SEP 2 7 2007 Registrar

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 9/19/2007 <u>Thomas Hadaway Robinson</u> /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 204 Byford Dr. Chestertown Kent Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. **Funeral** Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **1** M 2 □ F Director 214-14-1517 86 12/10/1920 MD Usual Residence of Decedent show 10a. State 10b. County 10c. City. Town or Location r 28a-f show notified at 10d. Inside City Limits Director 1 XYes 2 ☐ No MD Kent Chestertown 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? r than "natural", or Items 23a or the Medical Examiner must be 204 Byford Dr. filed within 72 hours after death Funeral 21620 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 □ No If Yes, Give Year or Dates: 1944 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 21 No ģ 1944-45 3 □xWidowed 4 □ Divorced Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 Is marked other than any Injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) 11 Line Manager Communications 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Robert Lee Robinson Susie Lee Hadaway 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Donna Mills/Daughter 4 Reed Ct. Chestertown, MD 21620 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chester Cemetery 9/22/2007 Chestertown, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Fellows, Helfenbein & Newnam Kuk of 130 Speer Rd. Chestertown, MD 21620 23a. Part1. Enter the disease, or conditions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final RUPTURED ABDOMINAL ANEURYSM Physician disease or condition resulting in death) twhours /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of, Examine the death certificate be executed as the burial-tran Due to (or as a consequence of): Box 68760. physician Physician/Medical attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death 5 ☐ Other (specify) P.0. ed by the a 1 ☐ Yes 2 ☐ No 9□Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by SCHEMIC CARDIOMYURATHY 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown RENAL INSUFFICIENCY 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed death? this certificate 1□ Yes 2 No 1 ☐ Yes 21 No or Attending Physician; director. To Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No Hospital: 1 Inpatient 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: completely filled in by the f 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined

DHMH 17 Rev 1/2001

State

Registrar

Hospital

To the

4 Homicide

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

and manner stated.

32. Registrade Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Helen A. Noble 122 Speer & .

SEP 2 4 2007 >

150 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Chestertown, MD 21620

29d. Date signed (Month, Day, Year)

200

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 32498 State of Maryland / Department of Health and Mental Hygien [ ] 1 - For State Registra Certificate of Death 2. Date of Death 1. Decement's Name (First, Middle, Last) **Physician** 12:05AM 700 /Medical County of Death 4b. City or Location of Death 4a. Fability Name (If not institution, give street and number) Examiner Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** 10M 20F Months Days Hours Min Yrs. Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State r than "netural", or Items 23a or 28a-f show the Medical Examinar must be notified at 1 res 2 □ No **Funeral Director** 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 0 filed within 72 hours after death 12. Was Decedent Ever in U.S. Armer Forces? 1 ☐ Yes 2 ☐ No Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc Specify: BIACL 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1943-45 1 ☐ Yes 2 ☐ No Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. OO NOT use retired) 16b. Kind of Business/Industry Decedent's Education (Specify only highest grade completed) Elementary Scondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden, Sumame permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If tiem 27 Is marked oth any injury or othar treumatic evant <u>once.</u> Be ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) torrest 20747 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 Removal from State \* 4 □ Deflation 5 □ Other (Specify) Furery Hone 22. Name and Address of Facility 21. Sign P.D. BOX 2543 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. ath. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Proumonia Pnysician unknow /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): by Physician/Medical Examiner attending physician and for use as the burial-transit To the Hospitel or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Year Month Dav 4□Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 🗷 Unknown obstructive pulmoney diften Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No 24a. Was an 2 X No 1 ☐ Yes Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 1 ☐ Yes 2 🔀 No 1 X Inpatient မ 3□ DOA this 28a. Date of Injury (Month, Day Year) Diractor: After th 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation death. 2 Accident 6 Could not be determined Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 T Homicide within 24 hours after To the Funerel Dira completely filled 29a. Certifier t 🗷 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Party Furn M.D D43446 9.8.07 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SHIVA 3-41 Silver spring 9001 Georgia Are Suit REINTAN FARAHIEAR M.D 31. Date filed (Month, Pay, Year) SEP 25 2007 32. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiens 1 - For State Registrar 32499 Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician 19 Sept Pearl  $\mathbf{E}$ Russell 2007 1:15 a<sup>M</sup> /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Hillhaven Healthcare Adelphi Prince Georges 5. Social Security Number **Funeral** 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth 9 1 7 1 9 1 7 9. Birthplace (State or Foreign Country) Maryland 1□M 2X1F Director 579-20-3481 90 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a State 10b. County or 28e-f show 10d, Inside City Limits treumatic event, the Madical Exacution rust be notified at Director 1X Yes 2 □ No Washington DC. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or Items 23a 3501 Idaho Avenue NW. 20016 #207 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Black þ 3 ☐ Widowed 4 ☐ Divorced natural', Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "any jujury or othar treumatic event, it a Magnes. Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Domestic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ပ Joseph Robinson R Pinkney 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Daniel Russel<u>l / Husband</u> 3501 Idaho Ave.NW#207 Washington DC 20016 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln 9/27/07 Brentwood, Maryland 22. Name and Address of Facility Adams Funeral Home PA 21. Signature of Fone al Service June 20605 Aquasco Rd. Aquasco, Maryland20608 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Alsy hmia Cardiac disease or condition resulting in death) 20 m(4 /Medical Due to (or as a consequence of): Examiner Diabetic Coma Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy jo in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death Month Dav Year 5 Other (specify) Division of Vital Records, P.O. detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Candiovasalas 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Dementia 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No Antery CORONATY 1 ☐ Yes 2 ☐ No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No Other: Certification: To 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Director: After this in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D1784 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3311 Toledo Terraco + Bloz traltsville Md-20182 VAID M.D YIVEK C 31. Date filed (Month, Day, Year) State Registrar

State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle,Last) Physician/ 2. Date of Death September 20, 2007 Medical Examiner 0. 1246 hrs Bruce Raison 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 1519 Carpenters Point Road Perryville Cecil 5. Social Security Number **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign Austrailia
Country) Months Days Hours Director 264-08-6522 1**X** M 2 F 56 05/25/1951 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No MD Cecil Perryville Director 10e. Street and Number 10f, Zip Code 10g, Citizen of What Country? 1519 Carpenters Point Road 21903 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 12. Was Decedent Ever in U.S. ges I and 2 should be filed within 72 hours after death wit of Health and Mental Hygiene.

If Item 27 is marked other than "natural", or items there transmatic event, the Medical Examiner must be. 14. Race - American Indian, Black, Never Married 2 X Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. X Yes 4 Divorced If Yes, Give Year 1972–1976 or Dates: 1 Yes 2X No specify: white Specify: ģ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 21215-0036 12 carpenter Home Depot 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Donald Raison Helen Gillespie other tranmatic event, 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Susan Raison (wife) 62 Green Ridge Road Newark, DE 19711 20a. Method of Disposition Baltimore, 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State Burial 2 X Cremation 3 Removal from State Pages 1 crematory or other place) tant: Silverbrook Crematory 09/24/2007 Donation 5 Other Specify: Wilmington, DE 21. Signature of Funeral Service Licensee NIOOMACK 22. Name and Address of Facility McCrery Funeral Homes, Inc. 3924 Concord Pike 238. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of the course course course cause or respectively arrest; shock, or heart **Physician** Approximate Interval failure. List only one cause on each line /Medical Death a. Hanging Immediate Cause (Final disease **Examiner** or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. if any, leading to immediate Due to (or as a consequence of): Examine 3 4.54 cause. Enter Underlying Cause (Disease or injury that it idlated events resulting in death) Last Due to (or as a consequence of): and - transit Hospital or Attending Physician: The law requires that the death certificate be executed sician/Medical attending physician a UNPENDED AMENDED Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 3b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Day signed by the attending be detached for use as Fetal death Month Year 2 past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown g Unknown Phy Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 ✓ No 3 Probably 4 Unknown Completed this certificate has been a il director, page 2 should 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? 1 🗸 Yes ✓ Yes 2 No 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 V Other: Scene ပ 1 ✓ Yes No After 28a. Date of Injury (Month, Day, Year) FOUND: 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Subject hanged self Natural FOUND: 5 Pending Yes 2 V No 24 hours after death. To the Funeral Director: completely filled in by the Sep 20, 2007 1240 hrs Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 V Suicide Could not be or Town, State) 1519 Carpenters Point Road , Perryville, MD (Specify) Single Family Homicide 29a. Certifier (Check only Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) Donna momanti, M.D. O.C.M.E. September 21, 2007 30. Name and address of person who completed cause of death (Item 23a) Donna M. Vincenti, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 ND 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

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